

Experiences of depression

Diagnosis, resistance and out-of-tune embodiment

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EXPERIENCES OF DEPRESSION

DIAGNOSIS, RESISTANCE AND OUT-OF-TUNE EMBODIMENT

BY
METTE TOFT RØNBERG

DISSERTATION SUBMITTED 2017



AALBORG UNIVERSITY
DENMARK

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MENT**

by

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ENGLISH SUMMARY

This thesis is an examination of the complex experiences of what we call depression in everyday life, including embodied experiences of depression. It is also an examination of the multifaceted and ambiguous experiences of getting a depression diagnosis, and an exploration of the in-depth processes involved in learning to live under the description of depression.

Research on depression is vast, ranging from work that deals with the phenomenology of depression based on mainly philosophical reasoning to macro sociological perspectives on multiple determinants to why so many people are haunted by depression in contemporary time. However, when it comes to qualitative research with a diagnostic perspective on depression based on first-person accounts, literature is sparse. The purpose of the thesis is to contribute to remedy this lack by investigating how adults understand, interpret and enact a diagnosis of depression in everyday life.

In the thesis, I follow the tradition of medical anthropology, in that I study the meanings people attach to experiences of depression as well as the macrosocial processes that impinge on it. I do this by paying attention to embodied, intersubjective, cultural and social dimensions of people's lives, insofar as I understand experience, a central concept in the dissertation, as socially and culturally embedded.

The thesis is based on ethnographic fieldwork among adults diagnosed with depression in Denmark. The empirical material that works as the pivotal point in the thesis is more specifically generated from interviews providing first-person accounts of experiences of depression. Furthermore, the fieldwork consists of observing and participating in meetings in a volunteer-based support group hosted by a patients' association, spending a week at a summer folk high school ("sommerhøjskole") for people diagnosed with depression, and observations in a depression group led by two psychotherapists at an outpatient psychiatric department. Finally, I have followed various depression fora on Facebook and the media coverage of depression. The fieldwork has whirled me into a world of pain, sorrows, disappointments, personal and social failures and normative expectations that are difficult to meet, but also one of hope, valuable existential considerations, care and communities

The thesis consists of ten parts. The first six chapters provide the introductory frame, where I present the methodical and theoretical framework of the project, and I place the thesis within existing research.

The first chapter is an introduction, followed by chapter 2 about methods and methodology where I also present the fieldwork.

In chapter 3, I provide a historical background that outlines where the diagnosis of depression comes from. This leads to the present-day diagnostic cultures where a psychiatric and biomedical understanding of suffering has become victorious. This is followed by a literature review of qualitative research on experiences of depression as well as diagnostic processes.

In chapter 4, I outline my approach to experience, and I place it within the anthropology of experience. I also review phenomenological themes qualitative studies on experiences of depression have examined.

In chapter 5, I outline what a diagnosis is, I present the sociology of diagnosis, and I review qualitative research that examines experiences of being diagnosed in general, and with depression, in particular.

In chapter 6, I present macro sociological perspectives on why so many people suffer from depression in contemporary time. More specifically, I depict voices that claim the high prevalence number is caused by a faulty diagnostic system, a powerful pharmaceutical industry and finally normative transformations of individuality.

This is followed by three articles that provide glimpses into experiences of diagnostic processes, as well as accounts of life with depression.

In the first article, “Struggling with a depression diagnosis: Negotiations with diagnostic categories”, I follow the life of a single person, Bridget, and her struggles with learning to live under the description of depression. The article deals with resistance and dispute in diagnostic processes and illustrates how these are not once-and-for-all-dealt-with matters but rather messy, complicated and variable processes, that involve several actors and multiple relations to the diagnosis. Bridget’s story furthermore depicts the dominance of a biomedical gaze and diagnostic categories when a person is to comprehend illness experiences in Denmark.

In the second article, “Living Under a Diagnostic Description: Navigating Images, Metaphors and Sounds of depression”, I explore how people use cultural repertoires on depression in the process of subscribing to a diagnostic understanding of suffering. I argue that metaphors, images and sounds play a significant part in the process of transforming clinical depression diagnoses into images that resonate with illness experiences and unique lives. I suggest that these cultural repertoires provide a space for a kind of inventive play with the diagnosis, pointing to a selectivity and creativity in how people relate to a diagnosis in present-day diagnostic cultures.

The third article, “Depression: Out-of-Tune Embodiment, Loss of Bodily Resonance, and Body Work”, is driven by an aspiration to examine illness experiences of depression rather than the diagnosis. Thus, I explore depression as an out-of-tune embodi-

ment, characterized by disturbances of bodily experiences and loss of bodily resonance. I furthermore depict my informant's endless efforts of trying to attune to the rhythm of everyday life through different kinds of body work. As in the first article, this article challenges the dominant diagnostic understanding of depression as a neurobiological, inner, and individual disorder, by arguing that depression primarily is experienced as a bodily and relational phenomenon in quotidian life.

I end with a conclusion where I summarize the general findings. Taken together, the three articles argue that the diagnosis of depression is negotiated, interpreted and used in a variety of ways by people living under the description of depression in everyday life. Hence, the incorporation of a depression diagnosis into the personal lives of the afflicted, happens in a range of ways, pointing to a flexibility, creativity and selectivity in how adults experience, interpret and use a depression diagnosis in everyday life.

I also illustrate in the thesis how experiences of depression and diagnostic processes are informed by and entangled with factors external to the individual such as normative desires of being a good person, of keeping a good job, and of being accepted in general. Another central argument in the thesis is thus that depression cannot be reduced to an individual or intra-psychic brain disorder, insofar as depression is experienced as a very bodily and relational phenomenon in everyday life.

DANSK RESUME

Denne afhandling undersøger, hvordan voksne erfarer depression i hverdagslivet. Det er et studie af kropslige erfaringer med depression, livet med depression samt implikationer af at få stillet en depressionsdiagnose. Det er også en udforskning af de mangfoldige og ambivalente måder, der er at forholde sig til en depressionsdiagnose på samt en dybdegående undersøgelse af, hvordan voksne lærer at leve under beskrivelsen depression.

Den videnskabelige litteratur om depression er omfangsrig og spænder fra en depressionsfænomenologi, som hovedsageligt baserer sig på filosofiske værker, til makrosociologiske perspektiver, som giver flere forskellige bud på, hvordan det kan være, at så mange mennesker lider af depression i vores samtid. Der mangler dog kvalitativ forskning, som med et eksplicit diagnostisk perspektiv på depression undersøger, hvordan voksne oplever at få stillet en diagnose, baseret på beretninger fra et førstepersonsperspektiv. Formålet med denne afhandling er at bidrage til at udfylde dette videnshul ved at undersøge, hvordan voksne erfarer, fortolker og bruger en depressionsdiagnose i hverdagslivet.

Erfaring er et centralt begreb i afhandlingen, og jeg følger den medicinske antropologis tradition for at undersøge sammenspillet mellem den betydning, som mennesker tillægger depression, og de makrosociologiske processer, som influerer disse. I praksis gør jeg dette ved at adressere kropslige, intersubjektive, kulturelle og sociale dimensioner af mine informanternes oplevelser af depression og diagnostiske processer.

Det empiriske materiale, som er omdrejningspunktet i afhandlingen, er baseret på et etnografisk feltarbejde i Danmark blandt voksne, som for nyligt er blevet diagnosticeret med depression. Feltarbejdet består mere specifikt af interviews, som har genereret førstepersonsberetninger om livet med depression samt diagnostiske processer. Derudover har jeg som en del af feltarbejdet deltaget i og observeret ugentlige møder i en støttegruppe for mennesker, som lider af depression, arrangeret af en patientforening. Jeg har også deltaget på en uges sommerhøjskole for mennesker med depression i samme regi. Derudover har jeg observeret et forløb i en depressionsgruppe på et psykiatrisk ambulatorium. Jeg har også fulgt depressionsgrupper på Facebook samt mediernes portrættering af depression. Samlet set har feltarbejdet viklet mig ind i en verden af smerte, sorg, skuffelser, personlige og sociale nederlag samt normative fordringer, som kan være vanskelige at leve op til. Feltarbejdet har også givet mig et indblik i en verden af håb, værdifulde eksistentielle overvejelser, omsorg og fællesskab.

Afhandlingen består af ti dele. De første seks kapitler danner en overordnet ramme, hvor jeg præsenterer afhandlingens metodologiske og teoretiske afsæt og placerer afhandlingen i den eksisterende, relevante forskning.

Kapitel 1 er en introduktion, som bliver efterfulgt af et metodekapitel, hvor jeg introducerer det feltarbejde, som afhandlingen er baseret på.

Kapitel 3 fungerer som et historisk oversigtskapitel, hvor jeg i korte træk redegør for depressionens lange historie. Dette leder frem til nutidens diagnosekultur, hvor en psykiatrisk og biomedicinsk tilgang til og forståelse af lidelse er blevet dominerende. Herefter kommer der en gennemgang af kvalitativ forskning, som beskæftiger sig med erfaringer med depression samt diagnostiske processer.

I kapitel 4 redegør jeg for min tilgang til erfaring, og jeg placerer denne i den gren af antropologien, som er fænomenologisk inspireret. Kapitlet bidrager også med en literaturgennemgang af fænomenologiske tematikker, som kvalitative studier af erfaringer med depression har undersøgt.

I kapitel 5 skitserer jeg, hvad en diagnose er, og jeg præsenterer den gren af sociologien, som beskæftiger sig med diagnoser. Kapitlet indeholder også en gennemgang af kvalitative studier, som undersøger erfaringer med at få stillet en diagnose i det hele taget og erfaringer med at få stillet en depressionsdiagnose specifikt.

I kapitel 6 præsenterer jeg en række forskellige bud fra makrosociologisk forskning på, hvordan det kan være, at der er så mange mennesker, som lider af depression i vores samtid. Nogle af disse perspektiver hævder blandt andet, at årsagen er at finde i et fejlslagent diagnosesystem, en magtfuld medicinalindustri og i normative transformationer af individualitet.

Herefter følger de tre artikler, som alle bidrager med et indblik i voksnes erfaringer med depression og diagnostiske processer.

Den første artikel, "Struggling with a depression diagnosis: Negotiations with diagnostic categories", er bygget op omkring en af mine kerneinformanter, Bridget og hendes anstrengelser med at lære at leve med en depressionsdiagnose. Artiklen beskæftiger sig med modstand og konflikter i diagnostiske processer og illustrerer, hvordan det at få en diagnose er en rodet, kompliceret og foranderlig proces, som involverer flere forskellige aktører og adskillige måder at relatere til diagnosen på. Jeg argumenterer desuden i artiklen for, at et biomedicinsk og diagnostisk blik dominerer, når individuelle lidelseserfaringer skal fortolkes, og at det er vanskeligt at anvende tolkninger, som afviger fra dette.

I den anden artikel, "Living Under a Diagnostic Description: Navigating Images, Metaphors and Sounds of Depression", undersøger jeg, hvordan folk anvender kulturelle repertoarer i form af billeder, metaforer og lyd i processen med at lære at leve under beskrivelsen depression. Jeg argumenterer for, at disse spiller en central rolle i processen med at transformere kliniske depressionsdiagnoser til billeder, som vækker genklang til individuelle lidelseserfaringer. Jeg foreslår, at disse repertoarer skaber et rum for en slags opfindsom leg ("inventive play") med diagnosen, som indikerer en

selektivitet og kreativitet i den måde, som folk relaterer til og anvender en depressionsdiagnose i nutidens diagnosekultur.

Den tredje artikel, “Depression: Out-of-Tune Embodiment, Loss of Bodily Resonance, and Body Work”, er drevet af et ønske om at undersøge erfaringer med depression frem for diagnosen. I artiklen analyserer jeg depression som en forstømt kropslighed, der er kendetegnet ved en forstyrrelse af kropslige erfaringer og et tab af kropslig resonans. Jeg skildrer også mine informanternes utallige forsøg på at resynkronisere til hverdagslivets rytme gennem forskellige former for kropsarbejde (“body work”). Som det var tilfældet med den første artikel, så udfordrer denne artikel også den dominerende diagnostiske forståelse af depression som en indre, neuro-biologisk lidelse ved at argumentere for, at depression primært erfares som et kropsligt og relationelt fænomen i hverdagslivet.

Jeg afslutter med en konklusion, hvor jeg opsummerer, hvordan afhandlingen samlet set giver et indblik i de mangfoldige og ambivalente måder, som folk lever under beskrivelsen depression på. Jeg argumenterer for, at der er en fleksibilitet, kreativitet og selektivitet i den måde, som voksne erfarer, fortolker og bruger en depressionsdiagnose i hverdagslivet. Derudover illustrerer jeg i afhandlingen, hvordan erfaringer med depression og diagnostiske processer er sammenfiltret med en række eksterne faktorer uden for individet, såsom hvad det eksempelvis vil sige at være en succesfuld person og normative forventninger om for eksempel at kunne passe et arbejde og være en god forælder. Et andet centralt argument i afhandlingen er dermed, at depression ikke kan reduceres til en individuel hjernelidelse alene, men også må forstås som et relationelt og kropsligt fænomen.

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CHAPTER 1. A PROJECT ABOUT EXPERIENCES OF DEPRESSION AND DIAGNOSTIC PROCESSES

Jasper: “I cannot imagine the future. I don’t have any pictures where I’m sitting with a family. No pictures are coming up in my head when I think about the future. It’s all just black and white. I don’t have any compass to navigate with anymore. I used to have that. I don’t dream of the future any longer. I’m tired now.”

Irene takes the word after Jasper. She is staring straight in front of her with her arms crossed: “I’m afraid how it all will end. I’ve been sick for two years now and I just want to get back to myself, on the path I used to follow, before I got sick.” She sinks into the chair and looks thoughtful.

Leila says that sometimes she doesn’t want to be here anymore. She has morphine pills in a drawer at home, and underlines that she would *never* do it: “But it’s so terrifying to have these thoughts. It’s frightening how one’s brain can go there. What if it takes it a step further?”

One of the two psychotherapists begins to speak: “It’s normal to have these kinds of thoughts, but it’s just not something we usually talk about. Yet, we know that many have these thoughts without acting on them.”

Gitte: “It’s difficult to see I have a future. I don’t care anymore.” She spreads her hands with a gesture of despair: “Everything went wrong. One time I cut my wrist and another time I swallowed pills. It wasn’t me who gave up on life but something else. Nothing had succeeded in my life!” She lists with her fingers how everything went wrong: “Children, family, work, love life. I just felt I had done what I could. That I lived the life I was supposed to live, so I just started to use violence on myself.”

I take a deep breath while writing in my notebook from the corner where I am sitting in the room looking at the group, who sits in a circle. The atmosphere is so tense and heavy. My thoughts wander back to the time where I visited my mother when she was hospitalized with depression. I could not recognize her. She was not the person

she used to be. She just sat there, staring into vacancy.

Therapist: “You calculate your options differently when you are sad. Time will do something in itself. The depression will ease.” And directed to Gitte: “It’s true, right?” Luckily, Gitte nods assent.

The therapist now turns the subject to how the participants can take good care of themselves. Jasper tells that he tries to remember to have a good night of sleep, sunlight, and to be healthy and social. Leila says that she walks the dog and forces herself to go to the gym with her boyfriend every week. I notice how my breath is a bit lighter now, and that the knot in my stomach has diminished. The therapist explains how it is important to try to continue the things you usually do during an episode of depression for example, to play squash and see your friends even when you don’t feel like doing it. Sometimes it’s a good thing to turn on one’s autopilot.

“I lost my self,” Gitte says. “I have no idea who I am or where I’m supposed to go.”

Therapist: “It’s not strange you are feeling like that at the moment. But it’s possible to find your footing again. I hope you will believe in that.”

This small glimpse into a depression group at an outpatient psychiatric department in Denmark illustrates how experiences of what we call depression profoundly affect daily lives, bodily sensations, dreams of the future, and interpersonal relations. Depression is about isolation, a biting solitude, and a sense of being cut off from oneself and others. The normal sense of belonging to a world that is shared with others is disturbed by an extensive feeling of being fundamentally out-of-tune. The world comes to look strangely detached, and daily tasks that used to be quite simple are suddenly experienced as climbing Mount Everest. Sometimes, this is followed by shameful and tabooed feelings of not wishing to take part in the world anymore. What we call depression is, at its worst, experienced as an overall altered way of being in the world, where the body becomes awkwardly strange and unmanageable. It is about a narrowing of the self, in the sense of feeling that you are not the person you used to be, and that it is impossible to get back on track, no matter how hard you try. The future is blocked, chaotic, and difficult to imagine, or even non-existing, as Jasper and Gitte express in the above excerpt. Overall, a profound sense of dissonance and discord permeate one’s being.

For all the participants in the depression group, their painful experiences and difficult life situations have been given a name and are diagnosed as depression. Participating in a depression group involves illness experiences to be interpreted, legitimized, and naturalized through a framework of depression. This little word, depression, is therefore a label that can have great force in reworking and reshaping experiences. Yet, depression is also a very broad and elastic category, which currently is being used in many different spheres with various meanings. Hence, individuals living with depression interpret, understand, and use the diagnosis of depression in a variety of ways.

This thesis is about the complex, painful, and multifaceted experiences of what we call depression, centered on the following research questions:

- How does depression unfold in everyday life, and how is the condition experienced among adults diagnosed with depression?
- How do adults diagnosed with depression negotiate, navigate, and interpret a diagnosis of depression?
- How do adults experience the process of being diagnosed with depression, and how do they learn to live under this particular diagnostic description?

Besides portraying how depression is experienced in quotidian life, this thesis is also about the many-sided and ambiguous experiences of getting a depression diagnosis, and an exploration of how it is to interpret illness experiences through a diagnostic and psychiatric vocabulary. In this way, it is an in-depth exploration of the complex processes involved in “learning to live under the description” (Martin, 2007) of depression in everyday life, including the many different efforts initiated to try and retrieve a compass to navigate life with.

American anthropologist Emily Martin has examined various ways of framing and using manic depression in an American context, and she uses the phrase “living under the description” to underline the “social fact” that her informants have been given a diagnosis (Martin, 2007: p. 10). With this term, Martin points to how a diagnosis can give rise to a new subject position, insofar as the diagnosis comes attached with a language to comprehend illness experiences through and importantly, certain cultural and social meanings that influence how suffering is experienced, understood, and enacted. The phrase furthermore refers to how it is not given what people take a diagnosis to be, but rather a matter actively determined by people who are “trying to place behavior, words, performance, and style in a field of meanings” (Martin, 2007: p. 10). Moreover, Martin emphasizes that a diagnosis seldom encompasses the whole person;

insofar as a diagnostic description is one out of many descriptions a person lives by¹. In the thesis, I borrow Martin's term to examine the processes involved in learning to live under the description of depression. I demonstrate how a depression diagnosis is not just passively perceived, but instead it is negotiated actively, deployed selectively, and used in a variety of ways by people suffering from what we call depression. As historian of medicine, Rosenberg tellingly writes, people are "not simply victimized, alienated, and objectified in the act of diagnosis," (2002: p. 257), but there are a range of responses to a diagnosis and a variety of ways of relating to it and using it in everyday life, as I intend to demonstrate in the thesis.

To study these topics and questions, I take my point of departure in first-person accounts of living with depression and from participating and observing in different field sites with depression on the agenda. The empirical material that works as the pivotal point in the thesis is more precisely generated from participating in meetings in a volunteer-based support group hosted by a patients' association, from spending a week in the summer at a folk high school ("sommerhøjskole") for people diagnosed with depression, and from observations in a depression group led by two psychotherapists at an outpatient psychiatric department. Besides following these fora where people suffering from depression gather with professionals, volunteers, and fellow sufferers, I have interviewed eight women and two men about their experiences with depression. Finally, I have followed depression fora on Facebook and the media coverage of depression. The fieldwork has whirled me not only into a world of pain, sorrow, disappointment, and personal and social failures, and normative expectations that are difficult to meet but also of hope, valuable existential considerations, care, and communities.

A central argument in the thesis is that the incorporation of a depression diagnosis into the personal lives of the afflicted happens in a variety of ways, pointing to a creativity and flexibility in how people relate to a diagnosis of depression in everyday life in the context of diagnostic cultures. More specifically:

¹ The French sociologist Alain Ehrenberg criticizes Martin for setting aside the fact that people really are suffering from a disorder by using this phrase, and for refusing that there is something in the illness that is independent of the cultural context. Ehrenberg writes that with this term Martin reduces "a psychopathological fact to a case of suffering whose elements are social," and hence, she is making the psychopathology disappear (Ehrenberg, 2010: p. 19). However, I believe this critique is unjustified, insofar as Martin emphasizes that her informants' experiences of course are painful, and in this way, she is not denying the reality of the suffering (Martin, 2007: p. 10). At the same time, she also points to the biological origins of the disorders (Martin, 2007: p. 29). However, Martin's main focus is to portray how experiences also are very much dependent on the cultural and social contexts that give particular meanings to the condition, which is part of the reason why I find this term excellent. Yet, this is not the same as refusing that depression has a biological origin and hence is "real", in the sense of being a psychopathological fact.

- I argue that diagnostic processes involve several actors and multiple relations to the diagnosis, and that they can be complicated and messy affairs that stretch and develop as time goes by (Article 1).
- I suggest that cultural repertoires of depression in the form of metaphors, images, and sounds provide a small space for “inventive play” (Kirmayer, 1992), pointing to a creativity and variability in how people make use of and relate to a diagnosis of depression in everyday life (Article 2).
- I challenge the dominant diagnostic understanding of depression as an individual brain disorder by pointing to how the complex phenomenon of depression is experienced as a very bodily and relational condition in quotidian life (Article 3).

Acknowledging the complexities of depression, and that all research is somehow partial, I do not claim to fully comprehend or represent adults’ experiences of depression in this thesis, or to have discovered definite truths. Instead, the thesis provides glimpses into diagnostic processes and non-reductionist portrayals of what it feels like to live with what we call depression in everyday life.

1.1. DEFINING THE MULTIPLE PHENOMENON OF DEPRESSION

It is difficult to define depression, insofar as the term is used today with a breadth and diffuseness similar to the previous usage of what is often said to be depression’s predecessor, melancholia (Ehrenberg, 2010; Jackson, 1986; Lawlor, 2012; Radden, 2003), which I depict further in chapter 3. There is, in other words, an inconsistency in how the term depression is used and understood among professionals and lay people (Pilgrim and Bentall, 1999).

In an economic context, depression is a sustained, longstanding decline in economic activity, for example the Great Depression in the 1930s where a severe economic depression took place worldwide where international trade dropped, prices fell, and unemployment rose and affected numerous people and families. In geology, depression is used to describe a phenomenon where a landform is sunken or depressed below the surrounding area formed by erosion- or collapse-related mechanisms.

In Denmark, the meaning of depression has changed in everyday language from characterizing mainly a pathological state to also being used synonymously with having the blues on a bad day without the speaker having any pathological intentions behind using this term. Common sadness, displeasure and disappointment over life, or simply just having a bad day is with increasing regularity named depression in everyday language to characterize emotional conditions that are not understood as depression in a psychiatric forum (Brinkmann, 2016: p.50, Videbech in Ulrich, 2016: p. 177–178).

This photo of an outdoor sign from a café close to where I live is an illustrative example of how depression currently is being used in an entertaining way in everyday lingo:



Simultaneously, a wide range of more or less unofficial substitute terms for depressive disorder has arisen in recent years for instance postpartum depression, seasonal affective disorder, masked depression, and male depression (Petersen, 2007: p. 38; Petersen, 2016: p. 26).

However, in this thesis I am studying what most people presumably associate with depression—the diagnosis of depression. Yet, the usage of depression in non-pathological contexts obviously influences how adults diagnosed with depression experience living under the description of depression in quotidian life.

In the “International Classification of Diseases” (ICD-10), the diagnostic manual used in clinical settings in Denmark, depression is defined as a mood disorder. Depression is either diagnosed as a “depressive episode” or as a “recurrent depressive disorder,” and specified as mild, moderate, or severe. The symptoms are centered on signs that have a downward directionality such as a lowering of mood, reduction of energy, and a decrease in activity (WHO, 2007: p. 86–92). I go more thoroughly into the diagnostic image of depression and the official clinical guidelines in chapter 3.

Overall, the concept of depression belongs both to ordinary language and to the technical vocabulary of mental health professionals (Pilgrim and Bentall, 1999: p. 265). In this way, the category of depression comes attached with a variety of meanings, ranging from having the blues on a bad day to severe cases of pathological depression requiring long hospitalizations, large doses of medication, and shattered dreams. Similar to the diversity of depression in a non-pathological context, individuals living under the description of depression experience, interpret, and enact depression in a variety of ways, as I demonstrate in the thesis. In this way, depression is a complex phenomenon that is used in numerous ways, just as it comes attached with various notions regarding causative theories, motivation, and cure.

1.2. THE DIAGNOSTIC CULTURE RESEARCH PROJECT

When I was an anthropology master student, I was, like many others, astonished over the high prevalence of psychiatric disorders and wondering what was at stake. Already at this time, my attention was caught by the psychologist Svend Brinkmann's work on diagnoses (2010). This eventually led me to conduct four months of fieldwork in New York City in 2011 among adults living with attention deficit hyperactivity disorder (ADHD), where I examined a North American tendency to frame mental disorders as potential gifts that come attached with certain profitable assets (Rønberg and Blæsbjerg, 2013, 2014). When Brinkmann received a Sapere Aude grant from the Danish Council for Independent Research for a four-year research project on Diagnostic Cultures in 2013, in collaboration with sociologist Anders Petersen, and issued a call for two PhD positions, I decided to apply. Besides an academic interest in suffering, psychiatric diagnoses, and their contemporary influential status, my personal motivation for entering the project stems from a family history of depression. I reflect on the meanings and significance of this in relation to the project in chapter 2.

The high prevalence rates worldwide for many psychiatric disorders are the starting point in the Diagnostic Culture Research project. Depression is, for instance, one of the top global health challenges of the 21st century, and the World Health Organization (WHO) expects depression to become the second leading cause of global disability by 2020 (Wittchen et al., 2011; WHO, 2008). Epidemiological studies suggest similar alarmingly high numbers when it comes to other mental disorders, for instance anxiety disorders and ADHD. A so-called "conservative estimate" is that 38.2% of the population in the European Union suffers from a mental disorder (Wittchen et al., 2011). A central concern that is often illuminated in the political debate in relation to this worrying situation is how these epidemics are very costly affairs. In the case of depression, the Danish Health Authorities estimate that depression is a cause of loss in productivity of about three thousand million DKK (Flachs et al., 2015).

The Diagnostic Culture Research project explores how we are to interpret these disturbing statistics of psychiatric diagnoses in general and of depression and ADHD in particular. Are there signs of genuine epidemics or processes of pathologization of normal human phenomena or both? The purpose of the project is, in other words, to go beyond the alarming prevalence numbers and empirically chart and analyze what currently is a stake from the following three angles:

1. How adults experience the process of receiving these diagnoses, and what it means for them to have their experience of suffering filtered through a diagnostic and psychiatric vocabulary
2. How depression and ADHD are constituted in public discussions of media, film, and television
3. How these diagnostic categories have emerged and developed historically to become influential in many people's self-understanding (www.dc.aau.dk).

The purpose of the Diagnostic Culture Research project is to “chart some of the ways in which diagnoses operate in people's personal lives and on a larger social scale” (Brinkmann, 2016: p. 14). My PhD project deals in particular with the first question, as I examine how depression unfolds in people's everyday lives as well as experiences of diagnostic processes from a phenomenological-inspired perspective.

The concept of diagnostic cultures refers to a “situation in which we increasingly interpret our suffering in the light of psychiatric conceptions and diagnostic terminology” in the Western hemisphere (Brinkmann, 2016: p. 2; Brinkmann et al., 2014; Brinkmann and Petersen, 2015). In other words, a diagnostic expansion has occurred where diagnostic languages and psychiatric diagnoses increasingly are being used in a variety of contexts outside the medical domain, where they originated. Diagnoses are now being used to satisfy a range of needs in institutional settings such as public health planning and in the bureaucratic management of health (Brinkmann et al., 2014; Brinkmann, 2016; Jutel, 2011; Jutel and Nettleton, 2011; Kleinman, 1988a: p. 9; Mayes and Horwitz, 2005; Rose, 2013; Rosenberg, 2002; Rosenberg, 2006: p. 130). Importantly, diagnosis has also come to play a significant role when suffering is to be understood and acted upon at an individual level. Another important aspect of the diagnostic cultures concept, with reference to my project, is the use of the term in the plural to underline how “there is not a monolithic agreed upon understanding of mental disorder delivered by the diagnosis, and there is no unitary way that the diagnostic language is used” (Brinkmann, 2016: p. 13). This point is important, as it resonates with the findings in my fieldwork where those living under the description of depression use the depression diagnosis in numerous ways, just as experiences of what we call depression are manifold.

There are several similarities between the concept of diagnostic cultures, and the substantial body of literature that provide excellent analyses of how we can understand the high prevalence and the contemporary willingness to interpret suffering through diagnostic and biomedical lenses. Some of these macro-perspectives suggest that for instance medicalization (Conrad and Schneider, 1980; Conrad, 2007), a flawed diagnostic system (Horwitz, 2002; Horwitz and Wakefield, 2007; Frances, 2013) and normative transformations of individuality and lifestyles (Ehrenberg, 2010; Petersen, 2011, 2016; Blazer, 2005) play a significant part in this respect. I delve into these critical macro-perspectives in chapter 6.

However, this knowledge is often produced with little reference to how those living under the description of these diagnoses in everyday life experience the diagnosis and how they use it. There is, in other words, sparse research on the voices of people being diagnosed with depression based on first-person perspectives, including in-depth investigations that zoom in on the complex processes involved in learning to live under the description of depression in everyday life. Simultaneously, I find that the qualitative research that does investigate experiences of diagnostic processes often are drawing too simplistic conclusions that does not provide faithful pictures of the changeableness and messiness that sometimes are characteristic of diagnostic processes. More specifically, I think the literature tends to represent experiences of getting a diagnosis in a too structured way that does not provide a truthful picture of the complex empirical realities people inhabit. A central contribution of the thesis is thus to qualify and nuance the literature of experiences of living with a psychiatric diagnosis by providing portrayals of the variability and changeableness of diagnostic processes.

In the thesis, I am inspired by the work psychiatrist Thomas Fuchs (2005a, 2013, 2014) has done on the phenomenology of depression. Like Fuchs, I too emphasize intersubjective and intercorporeal experiences of depression. Yet, a central contribution of the thesis to existing research on experiences of depression is to flesh out lived experiences of what we call depression by providing evocative descriptions of how depression is experienced in quotidian life. In this way, the analyses in the thesis are qualitatively different from those of philosophical reasoning on depression (Ratcliffe, 2012, 2015 and Fuchs, 2005a, 2013, 2014), because they are based on ethnographic fieldwork, which offers certain valuable insights about experiences of depression. In article 3, I further analyze what people diagnosed with depression *do* in everyday life to try to attune to the rhythm of everyday life by different kinds of body work. I elaborate further on my contribution to the existing research in chapter 2 and 4.

1.2.1. NAVIGATING THE DIAGNOSTIC CULTURE RESEARCH PROJECT

My affiliation with the Diagnostic Culture Research group has been of significant importance to my thinking, and to how my research process has proceeded with regard

to the initial framing of the project, to juggling with analytical ideas, and to the continuous constructive discussion within the group. Yet, one of the things I have struggled with since I started exploring experiences of diagnostic processes and depression as a part of the research project is that those who live under the description of depression in everyday life do not always find the diagnosis as significant, as we as researchers within a diagnostic framework do. During my fieldwork, I have occasionally been struck by how the depression diagnosis sometimes mainly seemed to play a part when I deliberately made it a topic of conversation in interviews. Put differently, the informants seldom talked spontaneously about issues related to the diagnosis per se in the field, for instance about how it is to be diagnosed with depression, including how a diagnosis influence one's self-understanding and imaginations about the future. Nor did they seldom speak about the boundaries between suffering common to all mankind and pathological cases requiring a diagnosis, the potential impoverishment or enrichment of the diagnostic language and similar topics, in which we are interested in in the group. This is not to say that they did not have a lot to say about these topics when I inquired about these questions. The point is rather that the diagnosis seldom played a significant role in the so-called natural setting in the fieldwork. Thus, I sometimes had a sense of somehow squeezing the diagnosis into my work, as so many other topics seemed to be of greater importance for some of my informants than the diagnosis in itself. For instance, obstacles trying to get the right kind of help in a healthcare system under economic pressure with long waiting lists, difficulties in relations with important others, dealing with trauma from the past and in the present, handling one's difficult, distressing feelings and emotions including one's job situation, love life, children, and the many different aspirations to try to get better and to gain control over depression, just to mention a few. I also experienced during the fieldwork that some of the informants mainly have a pragmatic relation to the diagnosis and did not give much thought to the diagnosis in particular, while others such as Bridget experienced the diagnosis as a significant life event. I come back to Bridget's story in article 1. These divergent reactions made me think, if we sometimes overemphasized the importance of diagnoses and diagnostic cultures in people's lives in the research group.

One way to go about this challenge is to rightly state that the depression diagnosis is the obvious reason why a person, for instance, signs up for a summer folk school that focuses on depression. Furthermore, it is common knowledge that an official diagnosis is a gatekeeper to treatment at a structural level (Rose, 2013; Jutel, 2011; Jutel and Nettleton, 2011; Brinkmann et al., 2014; Brinkmann, 2016). Hence, it was needless to talk directly about the depression diagnosis in the depression group, which they seldom did, as all the patients took it for granted that the others were diagnosed with depression as well, which they were. I am certain that this is a plausible explanation to some extent. But I also think that it hints at the variety of ways of relating to a diagnosis such as depression. Furthermore, it points to how the diagnostic language does not determine people's self-understandings completely in everyday life, as Brinkmann also emphasizes (2016: p. 72), and as I argue in article 1 and 2. As Martin

also writes, as mentioned previously, a diagnostic description is one out of many descriptions a person lives by, and thus a diagnosis seldom encompasses the whole person but rather captures elements of a person (2007: p. 10).

My way to deal with the occasional “absence” of the diagnosis, and thus try to stay true and do justice to my informants’ stories and to what I was experiencing and observing in field, has first of all been to try and be aware of the variety of ways people engage with and relate to a depression diagnosis in everyday life, as well as other categories they apply to comprehend illness experiences through. Furthermore, I have tried to provide thick and nuanced descriptions of my informants’ lives, the matters they struggle with, along with their experiences of depression. However, due to the significance of the contemporary diagnostic cultures, as well as the lack of literature explicitly dealing with experiences of diagnostic processes, the depression diagnosis is the rallying point in article 1 and 2. In article 3, the diagnosis is kept in the background in favor of a portrayal of illness experiences of depression alone.

1.3. STUDYING A REAL PHENOMENON

In the thesis, I follow the tradition of Hacking (1995, 2007), Martin (2007), and Brinkmann (2016) who all approach psychiatric diagnoses as “real” from a pragmatic point of view. This means that I am not interested in engaging in a discussion about the social construction of the depression diagnosis in the thesis, as I understand depression as “real”, in that it is a category people use on a large scale to comprehend painful illness experiences and difficult life circumstances. At the same time, I continuously address how the reality of depression and experiences of the diagnosis “depends on certain sociocultural niches and practices” (Brinkmann 2016: p. 65).

The fact that what we call depression today is an illness that goes back to ancient Greece also points to the “realness” of depression (Jackson, 1986; Lawlor, 2012). Furthermore, in contrast to culture-bound disorders such as *latah* in non-Western societies (Winzeler, 1984) and maybe also agoraphobia, anorexia, and some would say ADHD (Conrad, 2006, 2007) in the Western part of the world also points to the universal character of depression, as cross-cultural studies on depression reveal that depression occurs worldwide yet in different shapes (Kleinman, 1988a: p. 2–3; Kleinman, 2004; Kleinman and Good, 1985; Kitanaka, 2012, 2015). These findings underline the empirical reality of depression too as well as its status as a core psychiatric disorder.

This point of departure implies that I do not understand depression as *either* biological *or* a cultural construct, but I rather understand experiences of depression as constituted by multiple determinants and a complicated interplay of biopsychosocial forces following the tradition of several medical anthropologists (Jenkins, 2015; Kleinman and Kleinman, 2015; Martin, 2007; Nielsen, 2016). In the thesis, I more specifically study

experiences of depression and diagnostic processes by paying attention to the corporeal, intersubjective, social and cultural dimensions of people's lives. In this way, I am examining the interplay between the intimacies and experiences of everyday life, and the social and cultural sources and structural conditions that shape everyday existence. In chapter 4, I elaborate further on my approach to experience, which stems from medical anthropology's tradition of considering the meaning people attach to illness experiences and the macrosocial processes that impinge on this.

That I place the most emphasis on the social and cultural character of depression in the thesis, as the reader will discover, does in other words not imply that I refuse biological or brain-based explanations. I just argue that they too often are given too much significance in contemporary diagnostic cultures at the expense of personal, idiosyncratic, and social aspects of people's lived illness experiences. However, this is not the same as saying that these perspectives do not have something to latch on to.

1.4. STRUCTURE OF THE THESIS

In chapter 2, I outline the methodical framework for the project, and I introduce the multi-sited fieldwork that forms the basis of the thesis. I reflect on the methods I have used to gain insight about adults' experiences of depression and diagnostic processes, including the personal ordeal I experienced during the fieldwork, owing to the sensitive character of depression and my personal involvement in it.

The purpose of chapter 3 is to explore where the diagnosis of depression comes from by sketching some historical events that have led to present-day diagnostic cultures where a psychiatric and biomedical understanding of depression has become dominant. The changing conceptualization of depression demonstrates the cultural and historical contingency of the cultural categories available to interpret suffering through, as well as the universal aspects of the pain, the labels are supposed to denote. I end the chapter with a description of the official diagnostic definition of depression and the official guidelines on how to treat and diagnose depression.

Insofar as experience is a central concept in the thesis, I outline my approach to experience in chapter 4 and place it within the anthropology of experience. Briefly put, I approach experience within anthropology's phenomenological-inspired tradition of studying how people attribute meaning to suffering as well as the macrosocial processes that influence this. I also review phenomenological themes, qualitative studies on depression experiences, and place my own project within this literature.

In chapter 5, I outline what a diagnosis is, and I demonstrate how the role of diagnoses have changed in a historical perspective. I also present the sociology of diagnosis

along with a review of qualitative research that investigates people's experiences of being diagnosed in general and with depression in particular.

In chapter 6, I present the multiple determinants that have been raised especially by sociologists to why so many persons are haunted by depression in contemporary time. I depict perspectives that claim the high prevalence of depression is caused by a faulty diagnostic system and a powerful pharmaceutical industry. Finally, I depict literature arguing that normative transformations of individuality have prepared the way for depression's medical success. This is followed by the three articles.

In article 1 "Struggling with a Depression Diagnosis: Negotiations with Diagnostic Categories," I follow the life of a single person, Bridget, and her struggles with learning to live under the description of depression. The article deals with resistance and dispute in diagnostic processes and illustrates how these are not once-and-for-all-dealt-with matters but rather messy, complicated, and variable processes that involve several actors and multiple relations to the diagnosis. Bridget's story furthermore depicts the dominance of a biomedical gaze and diagnostic categories when a person is to comprehend illness experiences in Denmark.

In article 2 "Living Under a Diagnostic Description: Navigating Images, Metaphors, and Sounds of Depression," I explore how people use cultural repertoires on depression in the process of subscribing to a diagnostic understanding of suffering. I argue that metaphors, images and sounds play a significant part in the process of transforming clinical depression diagnoses into images that resonate with illness experiences and unique lives. I suggest that these cultural repertoires provide a space for a kind of inventive play, pointing to a selectivity and creativity in how people relate to a diagnosis in present-day diagnostic cultures.

The third article "Depression: Out-of-Tune Embodiment, Loss of Bodily Resonance, and Body Work" is driven by an aspiration to examine illness experiences of depression rather than the diagnosis. Thus, I explore depression as an out-of-tune embodiment characterized by disturbances of bodily experiences and loss of bodily resonance. I furthermore depict my informants' endless efforts of trying to attune to the rhythm of everyday life through different kinds of body work. As in the first article, this article challenges the dominant diagnostic understanding depression as a neurobiological, inner, and individual disorder by arguing that depression primarily is experienced as a bodily and relational phenomenon in quotidian life.

In the final chapter I summarize the main points in the thesis and outline avenues for future research.

CHAPTER 2. FIELDWORK AND METHODS – STUDYING EXPERIENCES OF DEPRESSION

I am not an outsider to the world of depression, as I have a family history of depression. My deceased paternal grandmother struggled with depression before I was born; it was not something we talked about in the family. I found out about it when I was 17 years old and my mother was hospitalized with depression, or with a broken heart, after my parents' divorce. At that time, I also learned that my maternal grandmother had used sedatives while my mother grew up and that my aunt also for some time experienced life as very difficult to live. In May 2015, while I was in the middle of my Ph.D., a terrible and horrific event occurred, which is still incomprehensible. My cousin took her own life at 25 years old. After struggling with a destructive eating disorder, which led to depression and not least an unforgivable mistake while she was in psychiatric care.

I do not consider myself as a person who has struggled with depression. Nonetheless, I met with a long-time friend during the final phase of my Ph.D., who inquired about my project. In the middle of our talk, it occurred to me that she considered me a person who has battled with depression. I think of it differently and do not agree with her. Sure, it is quite right that I have gone through bad times, as everybody else does, especially because of my mothers' depression, my parents' ugly divorce, and the aftermath. As a consequence of these life events, I have, of course, been extremely sad, frustrated and disappointed, just as I have felt a need to withdraw from social obligations now and then. But there has not been anything pathological to this, as I tried to explain my friend while we were sitting at the café. They had been perfectly normal reactions to difficult life circumstances, as I understand it, and I can see that my sister is struggling with some of the same issues, which confirms my interpretation. Thus, I insisted that my reactions and feelings were natural, understandable, and not something which should lead to a diagnosis of depression and consequently be understood by means of a pathological and deviant framework. Yet, my friend remembers things differently and has a broader perspective on what the term depression should include. And during our talk, I met her half way. Yes, it is correct, that I was referred to a psychologist by my general practitioner and in that way, depression is most likely registered in my medical record. I vaguely recall the doctor mentioning that word, but it was not something that I noted, or a label that I wanted to identify myself with. I rather saw it as a necessary evil, exemplifying how diagnoses are used as regulating mechanisms in the Danish Welfare state to grant access to treatment such as psychotherapy (Brinkmann et al., 2014: p.696).

This is the story I have about myself and the depression label, I might have or might have had. Just as two of my informants do, I refuse to understand myself as a person who is living under the description of depression, even though the diagnosis is noted in my medical record. Similar to my informant Bridget, whom the reader will meet in the first article of the dissertation, I do not use the word depression as a part of my self-understanding. Firstly, this is because I do not believe this is the correct term to capture the bad patches I have gone through, and secondly, because I, like some of my informants, have difficulty identifying with the negative associations and the unattractiveness that come with the depression label. We live in a time where the heart of depression, the inability to act, the negativity and the stagnation, stand as the exact opposite of what is being called for societally, viz. activity, extroversion and adaptability, as the sociologists Alain Ehrenberg (2010) and Anders Petersen (2011, 2016) have argued. Depression is, in other words, in conflict with societal norms. This can make it difficult to subscribe to a diagnostic understanding of one's agony.

Along the way in the research process, I have learned that there are a variety of ways in which a person can relate to, interpret, and live with a diagnosis like depression. In that way, I have nuanced my view on depression and psychiatric diagnoses in general and learned that there is a selection, reflexivity, and creativity to how people use, experience, and interpret a depression diagnosis in everyday life.

This background story is part of the reason why I embarked on this research field in the first place. Due to the fact that we are always an inherent part of the research process, especially in qualitative research where we actively use ourselves as a tool in the research process (Hastrup, 2010: pp.57, 59), I found it necessary to sketch my personal experiences with depression here, insofar as it undoubtedly has influenced my research project when it comes to getting access to field sites, my relations with informants, as well as the ongoing analytical process of organizing, interpreting, and writing about my findings. This raises some ethical and analytical considerations which I will continuously address in this chapter.

In what follows, I start by outlining how I have constructed the multisided fieldwork which forms the basis for the dissertation. Then, I invite the reader into the fieldwork by giving an in-depth description of the different field sites and a presentation of the persons I met here. Subsequently, I depict how I recruited informants for interviews, describe how the interviews were carried out, and I present the interviewees. Afterwards, I reflect on the ethnographic enterprise which in my particular fieldwork has involved a personal ordeal because of the sensitive nature of it. I furthermore reflect on working with and revealing personal experiences in research, and I consider how this has shaped the articles in the thesis. I end by considering my analytical and writing process as well as ethical reflections and with a brief presentation of the interviewees narratives of depression.

As with all qualitative research projects, “no claims can be made for the statistical representativeness of the sample” (Karp, 1996: p.12). However, one of the methodological forces of fieldwork is that it provides a certain depth of insight about depression which I feel confident that any statistical sample could provide.

2.1. CONSTRUCTING THE FIELD

From the beginning, my strategy has been to somehow make contact with adults recently diagnosed with depression and to gain access to sites where they gather. My ambition was to learn about experiences of being diagnosed with depression and to study the meanings people attach to the diagnosis of depression. Insofar as it is impossible to find an isolated Malinowskian island filled with people diagnosed with depression, I had to rely on the next best. I believed this was to search for places where people suffering from depression spent time or more likely, sites where they gather in some kind of community. Furthermore, I was inspired by anthropologist Emily Martin’s (2007) idea about fieldwork as an expedition, where you start somewhere and then let the fieldwork unfold according to what happens. I did not, in other words, have an exact plan for how the fieldwork was supposed to unfold when I started planning it and when I was present in the different field sites. My research process has, in other words, been characterized by flexibility, openness and unpredictability characteristic of anthropological method, rather than a strict step-by-step method (Berndtsson et al., 2007: p.258; Hastrup, 2003, 2010).

Moreover, I found Martin’s methodological expansiveness and her excellent way of collecting different assemblages of manic depression, and in that way mediating the various ways of thinking about and using this disorder in American society, appealing. Thus, I began the research process by sensitizing myself towards different sources on depression in general. I started to have an awareness of when and how depression (and mental disorders, generally) was on the agenda in the news flow. I came across an exhibition when walking on the street in Copenhagen about mental illness, which I attended, just as I stumbled upon a literature festival at which one of the events was with an author of an autobiographical book on antidepressant medication. I started to read depression memoirs such as William Styron’s (1990) classic, “Darkness Visible: A Memoir of Madness”, to watch television programs, listen to radio programs, and concentrate more attentively than usual when friends and family talked about issues related to my research project. And of course, throughout all this, I continuously oriented myself towards the academic literature on depression while simultaneously doing fieldwork and writing.

Eventually, my fieldwork consisted of observing and participating in five meetings in a volunteer-based support group hosted by a patients’ association, as well as other events in this forum; ten sessions in a depression group led by two psychotherapists

in a psychiatric forum, a week at a summer folk high school (sommerhøjskole) for people suffering from depression and bipolar disorder, and finally two days of observation at a medical clinic. Besides that, I have interviewed eight women and two men about their experiences with depression. Lastly, I have followed the news flow on depression, including TV and radio programs dealing with the topic and depression forums on Facebook, and have attended different public events with depression on the agenda.

The following display provides an overview over the different field sites.

Field site	Activity	Forum
Support group	5 meetings	Patient's association
Depression group	10 sessions	Psychiatric department
Folk high school	1 week	Patient's association
Medical clinic	2 days	Medical practice
Interviews	14 interviews with 10 interviewees	Different places in Denmark

In this way, the fieldwork has not been tied to a specific location in Denmark since it was impossible to remain in one spot and study experiences of depression. Instead, I did multi-sited fieldwork, using anthropologist George E. Marcus' term, to describe how the fieldwork consisted of fragmented field sites where I moved between different locations, spaces and places, groups of people and material, with depression (and the diagnosis) being the rallying point (Marcus, 1995; Tjørnhøj-Thomsen, 2003: p.98).

The construction of the fieldwork has thus to some extent been determined by a matter of coincidence, and practical and organizational constraints, as is often the case with fieldwork (Hannerz, 2006: pp.30–31). Simon Coleman and Peter Collins (2006) emphasize how the field “is constantly in a process of becoming, rather than being understood as fixed (‘being’) in space and time” (p.12). They emphasize how fieldwork is constructed through “a play of social relationships established between ethnographers and informants that may extend across physical sites, comprehending embodied as well as visual and verbal interactions” (Coleman and Collins, 2006: p.12). One of the benefits of this fragmented and multi-sited fieldwork was that I quickly learned that there is not one coherent idea about what depression is but rather a multiplicity

of ways depression is understood, enacted and experienced, just as there is a variety of ways of relating to and using a diagnosis of depression in everyday life.

In the following I describe the field sites in further detail as well as the difficult, but not impossible, process of getting access.

2.2. PRESENTATION OF THE FIELD SITES

The first place I did fieldwork was at a medical clinic in an inner-city area in Aalborg, a city in Northern Jutland, in which I spent two days waiting for patients with depression symptoms to enter the clinic. The purpose of spending time at the clinic was mainly to recruit informants for interviews. I observed six consultations where patients discussed symptoms of depression or, for instance, their dosage of antidepressants with the doctors and nurses. The Diagnostic Culture project had a contact at the clinic which made this set-up possible. The arrangement with the clinic was that I observed the consultations whenever a patient with depression symptoms came in. If I found it suitable, I introduced my project and asked if the patients were interested in participating in an interview at the end of the consultation. I recruited one participant for an interview this way. Besides that, I gained a small glimpse into how diagnostic processes can unfold, and I became aware of how different these processes can be, depending on the doctor's and patient's personality, their understanding of depression, and their attitude towards psychiatric diagnoses generally.

Early on, a month within my Ph.D., I contacted a patients' association working with depression, with an eye to gaining access to some of their services. The patients' association turned out to be very helpful insofar as they provided access to a self-help group organized by the organization. They furthermore invited me to participate in their annual weekly folk high school. I also participated in a couple of conferences on depression arranged by the association. Finally, they played a helpful part in recruiting participants for interviews.

In the process of getting access to the self-help group, I talked with five different project coordinators, who declined my request because of the sensitive and vulnerable nature of depression, before I found a group that opened its doors to me. Some of the reasons for their refusals were that they feared my presence simply "would prevent participants from showing up", and that they would "become insecure and find it difficult to open up". The group I eventually got access to had good experiences with a researcher participating in their meetings previously (thanks to this person who opened a passage for me). I also believe that revealing my personal experiences with depression to the group coordinator on the phone when she inquired into my motivation for doing the project played a part. It might have been that the disclosure gave me a position as a kind of member of an invisible community, helping to legitimize my

presence there, insofar as I let the group members know about my personal interest in depression.

The group met every week, yet the arrangement was that I was only to attend the meetings every second week to make sure that the participants still had a space where they could talk freely and undisturbed from my staring gaze and the scribbling in my small notebook. These meetings took place on evenings in a red brick building in a public house. The participants sat around a table in a room which was used as an atelier during the day; hence, lots of colorful paintings were covering the white walls. There was no official moderator, but the contact person, Leah, took up this role more or less. It varied who attended the meetings, and I saw both familiar and new faces around the table each time I was there. I tried to disturb the meeting as little as possible and let them unfold as they would have done without my presence. I quickly realized that this was not possible because of the general informal and social character of these meetings to which, for instance, Susanne, always brought her small dog which ran around our feet while we were talking. I sat side by side with the other participants, and due to the fact that we were most often not more than 5–8 participants, it seemed odd if I did not contribute to the conversation as they continuously approached me during the meetings. Yet, in general, I tried to keep back and stay in the background of the conversation. At times, when the topics were of a particularly sensitive character—if someone, for instance, was crying or if I myself was emotionally affected by the atmosphere in the room and the content of the conversation—I put away my notebook and stopped writing because it simply just seemed inappropriate. In this forum, I furthermore recruited one participant for an interview which meant we met once at his house and talked about his experiences with depression. Every meeting ended with the participants, including me, gathering in a circle to have a group hug because “hugs release a happiness substance” as Leah explained.

In this forum, the participants shared their experiences with various attempts to manage depression. They recommended good (and less good) psychologists, psychiatrists and other treatment options, as well as unofficial advice on how to handle depression with each other. They shared their struggles with navigating a psychiatric system under economic pressure with long waiting lists. Those who were on transfer income shared their frustrations about new political initiatives that affected their economic situation. They agreed on the injustice of how one of the participants who had private health insurance was able to see a psychologist from one day to the next, while others in a less favorable situation had to wait for months. This participant was an exception compared to the other participants who, in general, had a lower socioeconomic status².

² A classic work on depression and class distinction is George Brown and Tirril Harris’s publication from 1978. The reason why I do not deal with this theme in the dissertation is that I am interested in experiences of depression that run across classes, such as bodily experiences (see article 3). However, class distinction might be an important factor in how a person experiences the process of being diagnosed with depression; this could be a topic for future research.

I also listened to stories about processes of getting the right diagnosis and noticed how the participants seemed astonished when they discovered that this was not always a straightforward process, thereby indicating a general expectation that mental and somatic disorders ought to be discovered and treated in the same seemingly objective manner.

The depression group

The informal character of the meetings in the self-help group stood in sharp contrast to the much more formal and clinical character of the depression group that I observed at a clinic in a psychiatric outpatient department. The contrast between these two field sites emphasizes Marcus' point on how multi-sited fieldwork is like being in a landscape that changes across sites, thus requiring the ethnographer to also renegotiate her identity continuously (Marcus, 1995: p.112). In like manner, Hastrup writes, that the ethnographer continuously must position him- or herself in the social field. However, not all positions are possible, and the fieldworker must be flexible and welcome the positions that come forward. Eventually, the ethnographer's positioning depends on practical circumstances, and the social rules in a given field within which the ethnographer has to navigate (Hastrup, 2010: p.71).

In the depression group, I was placed on a chair in the corner behind the eight patients who were sitting in a circle together with the two psychotherapists. I did not say anything during these sessions except for the first time when I introduced myself. The patients were encouraged not to have any contact with each other outside the therapeutic room which was in contrast to the friendly atmosphere in the self-help group where they, for instance, met for bowling evenings and saw each other privately.

The depression group is part of the national and standardized “packet courses” (pakkeforløb), initiated by Danish Regions in 2011. The packet courses were created in the wake of a benchmarking report that revealed huge and unaccountable differences in the field of psychiatry across Denmark. Hence, the packet courses were initiated with the aspiration to a “ensure uniform course of treatment”, and “a better and more coherent course for the patient” (Region Capital Psychiatry, 2017, my translation). This initiative is furthermore part of a general tendency to streamline and bring treatment options in psychiatry in line with how somatic disorders are treated. The line of thought is that patients hopefully will recover from depression by following a stringent course of treatment, which by and large, is the same for everyone. It was one of the official “depression packet courses” (depressionspakkeforløb) in Danish psychiatry for outpatients, in which I became involved.

I contacted seven different psychiatric centers responsible for these packets before I got access to a clinic close to Copenhagen. Here, I observed ten sessions out of a twenty-week group course, where every session lasted one and a half hours. I furthermore obtained permission to read the patients' journals, observed three individual

consultations the psychotherapists had with the patients, and I had informal conversations with the psychotherapists as well as one formal interview. The two psychotherapists also read and commented on some of my initial writings based on my observations of the depression group, among other things (Rønberg, 2015). Finally, I did an interview with one of the patients at a public place, when the course was over.

The patients in the group consisted of two men and six women, aged between 26–60 years³. Half of them were employed respectively as a salesman, designer, caretaker, and radiographer, while the others were on sick leave or some kind of transfer income. Six of them were single, while two of the patients were in a relationship. In their accounts of situations that triggered depression were events such as divorces, long periods with invasive psychological illness or stress, worrying and stressful periods with children struggling with mental health problems. There was a great difference between how afflicted the patients were by depression and likewise differences in whether they were experiencing what in diagnostic terms is called “recurrent depression” (four of them) or were having their first episode of so-called “unipolar depression”. In overall terms, the group of patients seemed quite different, yet the psychotherapists made a huge effort in creating cross-cutting themes related to depression.

Just as with the self-help group, the observations of the depression group gave me a vivid and perceptive insight into experiences of depression and how these profoundly affect daily lives, interpersonal relations, and bodily sensations which I analyze as an out-of-tune embodiment in article 3. Besides listening to the patients’ sharing of experiences with each other, and the psychotherapists’ responses to all this, I also gained much from just sensing the heavy atmosphere in the room, the patients’ low and shivering voices, the blank looks, the tears shed, and by watching the always present handkerchiefs lying on the floor in the middle of the room, available and visible to all, as if these handkerchiefs with their very presence invited the patients to enter a vulnerable and emotional room.

The sessions started every Wednesday at 10:30 a.m. Like the patients, I often came ten minutes before, and like them, I sat down and waited in silence for the two psychotherapists to enter the room punctually. During this waiting time, I was most often, just like the patients, watching the white walls, occasionally looking out of the wide-open windows and the fluttering curtains, letting my gaze dwell on the back of the heads of some of the patients, at other times meeting the gazes of those who were facing my chair and wondering whether I should smile or not. I remember listening to the quick-walking steps from the corridor, imagining that the professionals working

³ As in the case with class distinction, age is not a factor that I focus on in particular in the thesis insofar as I am exploring phenomenological aspects of depression experiences that most likely cut across difference in age. However, it would be an interesting topic to delve into in future research, in that an increasing number of young girls between 15–24 years are prescribed antidepressants (Skovlund et al., 2017).

at the clinic, somehow were walking faster and more loudly than the patients with their soft and cautious footsteps.

During the sessions, the two therapists continuously came with comments about what is typical for depression and what part of the patients' feelings and experiences are related to this condition. For instance, when one of the patients said that he had difficulty remembering what to buy when going grocery shopping, the psychotherapists responded that the memory is disturbed during depression, and therefore it is not strange that he could not remember what to buy. Another example is when the therapists explained that "you have a tendency to speak with a low voice and to be very self-critical during a depression", when the patients talked about topics related to self-reproach and self-criticism. In this way, the therapists and the whole set-up of the depression group contributed to creating a particular depression narrative about the patients' illness experiences, both legitimizing and naturalizing their experiences through a depression vocabulary without directly making the diagnosis a pivotal point for the sessions. In this way, the observations made me witness some of the processes involved in learning to live under the description of depression and thus becoming (or refusing to become) a person who is living under this particular description. The depression group furthermore made me aware of similarities and differences in how depression is experienced and the endless efforts initiated to try to manage and overcome depression. These findings and analytical attentions provide some of the important background material for articles 2 and 3 in which I draw on my field notes from these sessions⁴.

The folk high school

Fieldwork is about trying to put one's self in the place of the other, Jackson (2009) writes, and about trying to "access and experience directly the lives that others live in *their own place*" (p.241). One way of doing this is to get practically and socially involved in the activities "that contextualize and condition the other's worldview" (Jackson, 2009: p.241). An important anthropological method in this aspect is *participation*, which refers to how the fieldworker engages and participates in social fields to learn about and sense what is at stake for the persons one is studying (Hastrup, 2010: p.71). Besides participating in the self-help group and the depression group, I also got the opportunity to do a week of uninterrupted and bounded fieldwork on a site where people suffering from depression gather, when I seized the opportunity to participate in a week's sojourn at a folk high school in beautiful surroundings on one of Denmark's many islands.

⁴ I have written about the depression group elsewhere where I used the empirical material from the depression group in great detail (Rønberg, 2015). However, this publication is not a part of the thesis, but the preliminary analyses from it have informed article 2 and 3.

The sojourn is arranged by a patients' association in collaboration with the folk high school where the stay takes place. The purpose of the sojourn is to help the participants to "regain vitality" by participating in a community with fellow sufferers. During the week, the participants stay at the folk high school on a 24-hour-a-day basis. The program consists of a combination of creative activities such as a jewelry workshop, a painter's workshop and singing in a choir, and sporting activities such as outdoor events, runs and walks, yoga and cycling. Furthermore, different talks about depression by various depression experts are scheduled during the week. Another central component of the sojourn is a varied and healthy diet and a no alcohol policy.

About sixty participants attended the folk high school; we were ten volunteers who tried to make the week run smoothly by taking care of practical matters and watching for the course participants' well-being, such as, for instance, noticing if anyone was sitting unwillingly by themselves for lunch and in that case joining them. When we introduced ourselves on the first evening, I made the participants aware of my dual role as both an anthropologist and volunteer, emphasizing confidential aspects and matters about anonymization. I also told about the small evaluation report that I had promised the patients' association I would do based on my participation at the folk high school and the ten brief interviews I was planning to do together with one of the other volunteers. The interviews were about matters such as how the participants experienced the sojourn, and their main challenges in everyday life.

Despite the stressful part of navigating several roles at once, the folk high school was a very impressive and amazing place to be, filled with such a warm and caring atmosphere which underlined the importance of communities, friendships and warmth in managing depression. This is a theme I deal with in article 3, which also provides a more in-depth description of the organization of the folk high school.

2.3. ON RECRUITMENT AND INFORMANTS

In this section, I describe my criteria for recruiting informants for interviews. I also outline the recruitment process and present the interviewees.

My main criteria for recruitment was that the informants should be adults above 18 years of age and recently diagnosed with depression. Initially, I wished to recruit persons who somehow were in a field of tension between the blurry boundaries of pathological depression and "normal" or "natural" responses to emotional distress and difficult life circumstances. This was partly due to my personal and academic interest in these boundaries, as mentioned previously. Thus, I deliberately searched for interviewees who were employed (or currently on sick leave from their regular employment or course of education), and not so ill that they were on a permanent transfer

income. I supposed the employment criteria would indicate a rather high level of functioning and thus also might lead to questioning the diagnosis. I furthermore chose to refuse inquiries from persons who were suffering from extreme cases of severe depression with repeated and extended hospitalizations, and from persons who had undergone electric shock treatment, which is the last resort doctors turn to when nothing else is working. I feared it would be too difficult for me to handle these extreme cases of depression in an ethically acceptable manner; thus, it was another reason for kindly refusing these calls.

To begin with, I also thought it would be interesting to start working with informants in the prime diagnostic phase, that is, at the time where they contact the general practitioner for the first time, suspecting depression. Yet, it turned out to be rather difficult and time-consuming to recruit these kinds of informants because it required that I spend long days at medical clinics waiting for patients with depression symptoms to come in. From spending the two days at the medical clinic in Aalborg, I realized that this strategy also would involve observing a lot of sprained ankles and runny noses. Thus, I chose to make a notice instead, which the patient's association distributed for me. Eventually, seven informants for interviews were recruited through this notice. I met the other three at the field sites.

As grateful as I was for the great help from the patients' association, I simultaneously feared that the informants I would recruit through this channel would be biased in the sense that they would all be involved with the patient association, and assumed that this would create a too narrow informant group. Luckily, I discovered that the inquiries I got, were mainly from persons who did not use the organizations' services. They had just seen my note on the Internet because they followed, for instance, the patients' association on Facebook. In the end, it turned out that only one out of the ten informants I did in-depth interviews with were actively involved in the patient association in the sense of using their services.

The following visual display provides a presentation of the interviewees:

Name	Age	Occupation	Time since diagnosis	Family situation	Treatment	Interviews
Tina	46	Psychology student (currently on sick leave)	5 months, severe depression	Lives with husband and two children	Medication and psychological therapy	1
Peter	34	Computer engineer	6 months, severe depression	Single	Medication and psychological therapy	2
Hannah	30	Television manager (currently on sick leave)	2 weeks, moderate depression	Lives with boyfriend	Medication and psychological therapy, yoga and mindfulness	2
Bridget	45	Development consultant	3 months, severe depression	Lives with husband and two children	Medication and psychological therapy, yoga and mindfulness, “air, light and laughter”	2
Yasmin	25	Philosophy student (currently on sick leave)	2 months, severe depression.	Single. Lives in a shared apartment with 2 roommates	Supportive conversations with her general practitioner and a nurse	1
Nanna	28	Designer student (currently on sick leave)	5 years ago, severe depression	Single	Medication and psychological therapy, mindfulness	1
Irene	56	Office worker (currently on sick leave)	5 months ago	Lives with her partner	Alternative treatment	1
Sarah	32	Nurse	6 months, severe depression	Lives with husband and two children	Medication and psychological therapy, exercise, change of diet, and gardening.	2
Leila	29	Designer	7 years ago, moderate depression	Lives with her fiancé	Medication and group therapy, exercise, walks the dog	1
Jürgen	61	Grammar school teacher	2 years ago, moderate depression	Lives with a new girlfriend	Medication, psychological therapy, self-help group.	1

Eight of the informants I interviewed were diagnosed with depression within the last two years before I met them, except two who were diagnosed 5–7 years ago. The informants were either diagnosed with moderate or major depression, and they often had a comorbid diagnosis such as anxiety, eating disorder, stress, PTSD, as well as physical ailments. However, my main focus in this dissertation is depression, although I acknowledge the entanglement of different causes (and diagnoses) in my informant’s

predicaments. In general, I do not distinguish whether my informants are diagnosed with mild, moderate or severe depression; instead, I lump them together into one overall depression category, insofar as I am investigating experiences of depression, and the processes involved in learning to live under the description of depression⁵.

The interviewees were characterized by being fairly resourceful in the sense of having high-level educations, being well-informed, financially well-to-do (except the two students), and not least, very active when it comes to searching for information on depression and initiating various efforts to somehow manage depression and get better. In fact, it was striking how the informants searched for information both before and after receiving the diagnosis. They searched the Internet for information on depression and consulted different online forums. They sought information about others' experiences with depression, e.g., by attending meetings at self-help groups, and they got advice on how to treat depression from different kinds of experts. They read books about depression, watched television programs, and some followed the intense public debate which has taken place in the news media in Denmark in recent years on psychotropic drugs and over- versus under diagnosis. They used different treatment options, such as group therapy or individual consultations with a psychologist or psychiatrist, including the intake and regulation of medication. Some attended more alternative practices, such as yoga or mindfulness, or paid to see a dietician to change their food habits. All things considered, these different sources provide different understandings of what causes depression and how it should be treated. In article 3, I analyze the many different attempts to manage depression as “body work”, aimed at re-establishing or altering bodily resonance.

The fact that the interviewees had the strength to respond to my notice and volunteer to be interviewed, emphasizes their surplus of mental strength despite the awful illness experiences. Several had very reflexive attitudes towards their experiences of being diagnosed with depression, and were following the public debate on diagnoses. This differs from some of the participants in the self-help group, in which the majority did not seem to have the energy or the interest to follow the news flow. By participating in and observing the self-help group and the folk high school, I also came to meet adults diagnosed with depression who in general had a lower socioeconomic status than the majority of the interviewees, who primarily were from the middle class⁶. This

⁵ I am aware that the severity of the depression can obviously influence the intensity of the illness experienced, as well as the diagnosed person's level of functioning.

⁶ Some elements in my empirical material point to a relation between level of education and socioeconomic status and a critical and reflective relationship with one's diagnosis. However, I do not have the material necessary to deduce anything more general from this. However, it could be an interesting topic for future research.

has led to a broad range of informants which hopefully has provided nuanced insights into experiences of depression.

I return to the interviewees at the end of this chapter where I provide a short vignette with the interviewees' stories of depression and diagnostic processes.

2.4. INTERVIEWING

Overall, I conducted 14 interviews that lasted between one and half to three and a half hours. They were all tape-recorded and transcribed as the informants are anonymized in the thesis. I wanted to keep in contact with a couple of the informants to establish a closer relation and to be able to clarify topics from the first interview, and four of my informants were interviewed twice (one man and three women).

The qualitative interview is conversational in nature, and can best be described as an interaction between interviewer and interviewee about themes of mutual interests, following Steinar Kvale and Svend Brinkmann (2009: p.2). The interviews I did followed the structure of a semi-structured interview in which the questions do not have an exact predetermined order. Instead, I had a draft of questions and topics I wished to cover (Kvale, 1994: pp.131–133). The interview guide was structured around themes such as triggering events of depression, experiences of depression and the diagnostic process, how depression unfolds and is experienced in everyday life, and medication and other attempts to try to manage depression. Many of my questions were phenomenologically inspired, insofar as they addressed the informants' experiences, feelings and thoughts on depression. The purpose was to encourage detailed descriptions of their experiences of depression (Tinggaard & Brinkmann, 2010: p.31). To give a few examples, I asked “how do you experience feeling depressed?”, “how would you explain what depression is in your own words?”, and “how do you experience the medication?”. Other questions set the stage for retrospective narratives, when I asked, for instance, if they would describe the process of getting the diagnosis, including the chain of events that preceded the diagnosis.

We also talked about ideas related to the good life, resulting from questions such as “what is a good life for you?”, and “what does it mean to be successful in your life?”. These questions referred to societal and normative questions about how we ought to be as persons in order to succeed. Lastly, the questions were related to societal and public discussions on depression and diagnosis. Talking about these kinds of topics with my informants required a certain tactfulness in order not to minimize or neglect their experiences and diagnosis. I got around this ethical dilemma by framing the question such as “some people say that too many people are getting psychiatric diagnoses nowadays; what do you think of it?” I did not sense that any felt offended by the question. Rather, it started thorough reflections about social criticism—reflections on the debate on over versus under diagnosis of mental illness in general in Danish

society, and accounts of situations where they had experienced that others did not take their suffering and diagnosis seriously because “everyone is depressed nowadays”.

Being busy with fieldwork in the depression group and the self-help group, eight months passed before I arranged a second round of interviews to follow up on topics from the prior interviews and events that had happened meanwhile (e.g., extension of sick leave, getting back to work, depression worsened, starting medication up), as well as new topics that had caught my interest. The second round of interviews were fruitful in that they made me aware of the importance of time in diagnostic processes, and they emphasized the changeable, variable, and contradictory relation that the same person can have with a depression diagnosis. There are topics I engage with in detail in article 1.

Overall, the interviews can best be described as informal, conversational, and sometimes very intense, sensitive, and tearful. During the interviews, I made an effort to listen attentively and not to interrupt and give good advice. In this way, the character of the interviews I did were more in line with the therapeutic interview than, for instance, the discursive interview (Kvale & Brinkmann, 2009: p.41).

I preferred to visit the interviewees at their homes so that I could get a more holistic impression of them. Hence, all the interviews were held at the informants’ homes except two which were conducted in public places at the request of the informants. Apart from being motivated by a wish to help others, I got the impression that one of the informants’ main motivations for participating in the interviews was the opportunity to talk about their painful experiences with someone willing to listen patiently. As one of my informants, Hannah jokily put it: “When do you ever met a person who feels like sitting and listen to you for hours?”. People often state that they find it relieving to share their experiences with someone who listens respectfully to their stories of suffering, while acknowledging their agony when they reflect upon their experiences of participating in interviews (Gammeltoft, 2003; Karp, 1996: pp.22–23; Kvale & Brinkmann, 2009: p.32).

In overall terms, the interviews made me broaden my focus from an interest in the interface between the pathological and the “normal” to a broader focus on diagnostic processes in general, and an awareness of the wide spectrum of phenomenological issues related to experiences of depression. Furthermore, I became aware of the endless amount of efforts the informants continuously initiate in the aspiration to try to regain control over depression.

In the next section, I reflect on the intersubjective character of ethnographic fieldwork and I consider how the personal ordeal that I experienced during the fieldwork has shaped my findings and the written articles.

2.5. STUDYING SENSITIVE EXPERIENCES AND REVEALING PERSONAL STORIES

During the fieldwork, I was often asked about my reasons for doing the project, which posed some ethical and analytical dilemmas. It varied when I chose to disclose my personal story and how much of it, and when I withheld it. I sometimes used it somewhat strategically, mainly in the process of getting access to the field, as mentioned previously, where I thought that a revelation might help me to gain a foothold.

Inspired by David A. Karp (1996), I also occasionally thought that a revelation might create a confidential space in which the informants might feel more comfortable and inclined to disclose their inner private feelings. Yet, in practice it seemed inappropriate and wrong to use it this way. Hence mostly, I found myself spontaneously revealing my personal experiences in the fieldwork in situations where I felt somehow insecure and that my presence was intrusive. Sometimes, it was not enough to tell myself “I am an anthropologist; this is fieldwork” (Behar, 1996: p.6), to drain uncertainty and nervousness from situations in which I, for instance, felt helpless to release others from suffering, or from intruding with my presence into these vulnerable places. Hence, I believe that these disclosures were spontaneous attempts to try to legitimize my presence in situations where I felt uncomfortable and imposing. In these situations, I most often started by telling the story about my mother who got early retirement because of depression. Sometimes I would simultaneously mumble something about how I might have been somehow depressed myself, indicating my doubt about this as well. These hesitant exposés sometimes led to questions about how my mother is doing nowadays, and I sensed that they somehow were longing for a positive story to mirror themselves in. At other times, I felt inclined to share experiences from my own life, especially if I was moved by a certain situation that somehow resonated with my own life. I particularly remember interviewing Sarah shortly after my cousins’ and our family’s terrible tragedy, and how I felt an urge to disclose this to her, maybe because I felt a special friendly connection with her. Yet, I withheld my inclination to share it because I sensed that Sarah at this point was searching for positive stories after a long period during which the discouraging statistics about the risk of recurrent depressions and suicidal thoughts had haunted her.

In overall terms I was very hesitant to address my own family history of depression in the fieldwork, mainly because the interviews and the conversations I had with the informants in the other field sites were about their experiences with depression, not mine. Nevertheless, I occasionally found that my own experiences with depression were valuable in the fieldwork insofar as I learned that when I acted vulnerably and revealed personal experiences, it sometimes created moments of trust and interconnectedness, as autoethnographic work has shown can be the case (Karp, 1996; Kofod, 2017; Martin, 2007). Yet, it is difficult to determine if my sharing actually made a difference in creating a confidential space or if the informants rather attached greater importance to issues like empathy and personal chemistry in the interview situation.

The responses I got from the interviews were mainly that I was a good listener, that it was relieving to share their stories, and that they felt comfortable in the situation. No one directly addressed that my personal history played a significant part.

Anthropological knowledge is based on “an intersubjective process of sharing experience”, Jackson writes (1996: p.8), referring to the intersubjective model of understanding, characteristic of anthropology. In this way, participation as a method, is also about *involvement* in another person’s life through imagination, empathy, and by drawing on one’s own experiences in order to “momentarily identify ourselves with the world of others” (Gammeltoft, 2003: p.286, my translation). Hastrup writes in a like manner that “worlds are different but they are all populated by people who are able to imagine each other” (1992: p.47, my translation). We can, in other words, use our imagination, empathy, and experiences from our own life to try to understand what other people are experiencing.

In that respect, a central debate within the anthropology of experience is whether we must have experiences similar those of our informants to fully comprehend the phenomena we are studying. The most radical position in this debate is raised by anthropologist Renato Rosaldo’s (2003 [1984], 2013) who claim that understanding of a phenomenon, especially in cases of suffering, is conditional on having experienced the same or something close in order to fully comprehend these experiences.

In this thesis, I rather follow Karp, insofar as I do not believe it is necessary to have experiences similar to those of the informants to examine and understand experiences of depression (2006: p.258). Rather I hold, following anthropologists Tine Gammeltoft, Kirsten Hastrup, and Michael Jackson (2009), that emotional involvement with other human beings and “a sharpened ethnographic attentiveness” (Hastrup 2010: p.71, my translation), in the sense of being attentive to how suffering is expressed in speech and being as well as the feelings the situations in the fieldwork invoke in us, can provide valuable glimpses and insights into other people’s experiences. This is not to claim that I am able to experience what my informants are experiencing. As Clifford Geertz (1993) writes, we cannot enter into other people’s minds, and we cannot ensure that we perceive and experience the world in the same way as others (p.58).

Rosaldo may be true that there is something ineffable about certain radical experiences that can only be fully appreciated if one undergoes a similar experience oneself⁷. And then, it is still not certain, that we are able to fully comprehend it, at least not in the case of depression, insofar as depression often is portrayed as such a painful condition that it defies language and makes the sufferer unable to describe it, thus making it also difficult for outsiders to comprehend (Jamison, 1997:p.174; Karp, 1996; Ratcliffe,

⁷ Childbirth is a common example used to support this claim (Carel, 2013).

2015:pp.1–2; Styron, 1990; Trivelli, 2014)⁸. However, this does not entail that we should not try to understand the world of others, and that it is impossible to gain valuable insights into other people’s experiences.

These reflections and small episodes from my fieldwork demonstrate the inherently interpersonal and intersubjective enterprise of the ethnographic fieldwork. The ethnographer is an engaged actor who becomes socially and intersubjectively linked to “those whose lives they hope to understand” (Willen & Seeman, 2012: p.2). Even more relevant is Jackson’s (2009) point on how fieldwork “can place steep demands on ethnographic subject and inquirer alike” (p.239) because of the deeply interpersonal affair of ethnography. As Jackson tellingly writes, “understanding others requires more than an intellectual movement from one’s own position to theirs; it involves physical upheaval, psychological turmoil, and moral confusion” (Jackson, 2009: p.239). Fieldwork can, in other words, impose great demands on both the fieldworker and the informants’ bodily and emotional resources, especially when working in a sensitive field. Sometimes, this involves the ethnographer’s own identity and stability being risked “in order to explore the possibility of knowing the world other than how one has known it before” (Jackson, 2009: p.241). In this way, studying experiences and trying to understand a phenomenon as it is experienced from the point of view of another, requires both “dispassionate observation” and “personal ordeal” (Jackson, 2009: p.242).

In article 3, I implicitly use my own experiences with depression and the personal ordeal from the fieldwork as a methodical force to mediate experiences of depression as an out-of-tune embodiment. More specifically, I use my own body “as an instrument of resonance” (Svenaesus, 2014) to portray depression as a bodily condition that profoundly alters one’s way of finding oneself in the world. I mainly use this as a stylistic and evocative attempt to mediate experiences of depression as an out-of-tune embodiment and to try to evoke the tense and vulnerable atmosphere so often prominent in the fieldwork.

In closing, I wonder what kind of reflections (and articles) it could have brought if I have dared to go the whole way through and deliberately use my own emotional involvement with depression as an asset to help grasp the phenomena of depression better in both the fieldwork and in the analytical and writing process. Retrospectively, I believe there are unexploited analytical possibilities in this that might have taken us somewhere we otherwise could not get to in the difficult aspiration of trying to mediate the non-communicable nature of depression. Yet, the fear of navel-gazing and the

⁸ Simultaneously, researchers ponder whether certain media such as sounds, poetry and art might have a certain role to play in mediating what depression feels like when words are insufficient (Ratcliffe, 2015: p.2). I touch upon this in article 2.

risk of being too sentimental and creating embarrassing exposures for its own sake (Behar, 1996: p.14) made me hold back and only do it partial in the third article.

2.6. ANALYZING AND WRITING

Anthropologist Ruth Behar (1996) tellingly captures the frustrating, winding, and engaging expedition of doing fieldwork, as well as analyzing and writing about it, the following way:

Loss, mourning, the longing for memory, the desire to enter into the world around you and having no idea of how to do it, the fear of observing too coldly or too distractedly or too raggedly, the rage of cowardice, the insight that is always arriving late, as defiant hindsight. A sense of the utter uselessness of writing anything and yet the burning desire to write something, are the stopping places along the way. At the end of the voyage, if you are lucky, you catch a glimpse of a lighthouse, and you are grateful. Life, after all, is bountiful. (p.3)

In a similar way to how Behar tellingly describes the messy character of the ethnographic enterprise in its different phases, the process of doing fieldwork within a sensitive field, as well as analyzing and writing about it, have been challenging, explorative, and continuous activities. As with the fieldwork in which I did not follow a strict step-by-step method, so has the process of organizing, analyzing, interpreting, theorizing, and writing about my empirical material been a messy, chaotic, and intuitive process, characterized by a certain flexibility, openness, and unpredictability. In the process of writing the thesis, I have continuously moved backwards and forwards between different empirical sources, theoretical foundations of inspiration, as well as the pragmatic consequences of meeting certain deadlines. In this section, I intend to describe how this analytical and writing process has proceeded.

Despite the seeming messiness, the guiding principle in my analytical strategy has first of all been data-driven. In practice, it has been characterized by a process of reading and rereading the entire empirical material multiple times as a way of deepening the analytical process and to become familiar with the material. I did not subscribe to a specific coding strategy, but I coded the material by writing comments in the margins of both interview transcriptions and field notes during these readings, just as I wrote memos based on specific themes which I found interesting and significant (Tanggaard & Brinkmann, 2010: p.47). At one point, I also used Nvivo, a qualitative data analysis software, as a tool to systematize the material into thematic clusters.

Assignments along the way, such as papers for Ph.D. courses and conferences, and a chapter for an anthology on diagnoses (Rønberg, 2015), forced me to start writing

about specific themes in the fieldwork, at an early stage. After deciding on a topic for these assignments which had caught my interest during the fieldwork—for instance “the body’s part in depression”, to be used for a Ph.D. course with Nikolas Rose, six months after I started the Ph.D.—I reread the material I had at this point once again, this time with this particular focus in mind, cutting out passages dealing with the theme, and collecting them into an assembled document from which to start writing. After several redrafts, this paper eventually led to article 3.

An event that furthermore has inspired and influenced my analytical and writing process (as well as the character of my empirical material), is a Ph.D. course I attended with the poet and anthropologist Michael Jackson. Jackson encouraged us to try to focus on something other than words when doing fieldwork, to challenge the tendency to be drawn to words and utterances. Thus, I decided to experiment with having certain observation points in the depression group. More specifically, I tried to have an explicit focus on the patients’ bodies during the observations, including the timbre, rhythm, and gestures in their voices (Narayan, 2012), to try to avoid the words getting in the way of my senses and intuition (Wikan, 1992: p.470). I believe these observation points were, in combination with the paper for the Ph.D. course, one of the first steps towards article 3 where I approach depression as an out-of-tune embodiment.

In relation to article 1, I retrospectively believe that my own personal experiences with rejecting the idea of understanding myself as someone who lives (or has lived) under the description of depression, is the background and main motivation for my fascination with Bridget’s story into which I decided to go deeply and write a whole article about. Furthermore, I found Bridget’s way of relating to the depression diagnosis interesting insofar as her reasons for resisting the diagnosis resemble the critical sociological literature on diagnosis which I depict in chapter 6.

One of the driving forces behind article 2, where I use metaphors, images, and sounds of depression as a starting point, was that I continuously stumbled upon how literature on depression in several places portrayed depression as an indescribable condition (Jamison, 1997: p.174; Karp, 1996; Ratcliffe, 2015: pp.1–2), and expressed an astonishment at the richness in the informant’s metaphorical descriptions of depression. This made me consider whether certain media such as music, art, and poetry might play a helpful part in mediating these inexpressible experiences (Brinkmann, 2012; Ratcliffe, 2015: p.2). Later I narrowed the focus on the role of metaphors, images, and sounds in the process of learning to live under the description of depression, keeping the particular diagnostic perspective, I have on depression in the thesis in mind.

In overall terms, the analytical and writing process have been characterized by a dynamic and dialectic process of moving between certain themes stemming from the material, certain topics and concepts that have had my academic and personal interest from the beginning, and the existing literature on depression. During the process I

learned that it was especially in the messy, chaotic, and sometimes very frustrating process of writing that the analysis took form and eventually became a text.

As Tanggaard and Wegener (2017) emphasize, writing is a process of perception. More concretely, writing is a process of thinking, experimenting and trying out new ideas on the material. Tanggaard and Wegener (2017) furthermore point to how intuition is a part of the analytical and writing process, in the sense of feeling that you are on the track of something which is still unclear and undeterminable, before you finally catch a glimpse of the lighthouse after what can seem to be a long and never-ending voyage. And suddenly, all the messiness materializes into a finished and coherent text.

2.7. ETHICAL CONSIDERATIONS

Even though I continuously have considered ethical dilemmas in this chapter, I find it necessary to dedicate a section that explicitly engages with the topic insofar as I am studying sensitive matters that involve other people's painful experiences and intimate aspects of their lives.

First, the project is approved by the Danish Protection Agency (“Datatilsynet”). Furthermore, all names are pseudonyms chosen for reasons of confidentiality, just as personal aspects that might disclose the informants' identities are blurred. Before the interviews, I informed the informants about the purpose of the project and underlined that they could withdraw from it at any time. In the field sites I also obtained consent approval from the informants, and I further informed them about the project as well as issues concerning anonymization and confidentiality.

Baarts (2010) writes that research ethics not only are rooted in standardized ethical directions but also closely linked with being a good person, referring to how ethics are deeply rooted in moral, cultural and social life (p.159). Research ethics happen, in other words, not only before we enter the field and in the process of analyzing and writing about the empirical material, but to a great extent when we are present in concrete situations in the fieldwork. This requires the ethnographer to continuously consider how to act respectfully in the field. In the interview situations I have tried to behave properly by expressing empathy with my words and bodily gestures, and by giving space for silence, tears, and emotions. I often experienced that the interviewees got ahead of my plan to prepare them should they be emotionally affected and exhausted during the interview, and that they should say if there were topics they did not want to talk about. However, before I got a chance to say this, they often started out themselves by saying that they might become upset and emotional during the interview, which I should not bother about, and that they were used to talking about sensitive matters.

Brinkmann (2010: p.437) writes about how both interviewer and interviewees can be seduced by the openness characteristic of interview situations that resemble especially the therapeutic interview. The researcher's well-intentioned empathy and care can, in other words, lead to situations where the interviewee suddenly finds herself revealing experiences that she might regret afterwards, and that may lead to upsetting emotional distress. I can recognize this ethical challenge in my own project, in connection with the interview I did with Tina, which the reader will meet in article 3. At the time of the interview, Tina was just slowly starting to escape the depression's tightening grip when I visited her in her home, and her agony moved me deeply, as I depict in the article. At one point in the interview, I inquired into the reasons for her depression. She paused and contemplated it for a while, before she told me in detail about a terrible incident with her close relatives that eventually led to a split-up that still hunts her. Nevertheless, the point is that she told me about details which I have chosen to leave out in the article insofar as I estimate that these details are so private that it seems inappropriate to include them. Furthermore, I am not certain that it was her intention to involve me so much as she hesitated and said that only a handful of people knew about these details. Afterwards, I wondered whether she regretted her openness, but I do not know because I lost touch with her. Thus, I have chosen to cut out these details.

Another ethical reflection I want to include is about disclosing my family history of depression. Insofar as depression is a sensitive topic and in many ways is still very taboo despite the parallel detabooization that has taken place, I have asked for permission to write about it in the thesis. Thus, my mother has read the small passages that involve her, commented on them, and approved them.

2.8. BRIEF PRESENTATIONS OF THE INTERVIEWEES

All of the informants I have met during the fieldwork have informed the thesis. However, some of the interviewees' narratives are presented in modified or extended version in the articles, while others are more implicitly present when I for instance analyze bodily experiences of depression and the endless efforts the informants initiate to try and recover from depression. In this section, I provide a short vignette with a brief presentation of each interviewee to provide some context for the interview data that forms the basis for the thesis. I want to emphasize that these are only partial glimpses into the realities of living with depression and experiences of diagnostic processes.

Tina

Tina is 46 years old and lives in a small town with her husband and their two sons in a typical Danish residential neighborhood with red brick houses and trampolines in the gardens. Tina used to work as a pharmacologist but she got fed up with it a couple

of years ago. Hence, she decided to change her life and enrolled in a psychology program. She is currently on sick leave.

Tina was not surprised to discover that she suffered from depression. As in the case of my other informants, Tina experiences the diagnosis as very ambivalent. She feels relieved about the diagnosis, insofar as it helps her to accept her situation. It also helps her to legitimize that she is not able to take part in the things she used to do. In this way, the diagnosis helps her to let go of her constantly bad conscience. She also experiences that the diagnosis made her husband understand her situation better. At the same time, she is afraid that others do not take the diagnosis seriously, insofar it has become a term that people use all the time. Finally, the diagnosis has given her access to treatment that she finds very helpful.

Tina is very fond of her psychologist who she sees weekly, and she is fond of the antidepressants she takes, even though she “does not like to take medication that influence the central nervous system”. Nevertheless, she reports that the medicine is very helpful, insofar as it gives her more energy and lifts her mood. These efficacies make up for the side effects she is experiencing such as decreased sexual series and mouth dryness.

Tina believes her depression to be caused by a combination of inner and outer circumstances. She thinks that the mental stress she experiences due to a family crisis and a split with her parents, influence the brain’s neurophysiology. In overall terms, she understands depression as a disease, triggered by a combination of difficult life circumstances and genetics. Tina and her husband use the disease narrative about depression, when they try to explain the children that it is not their fault that their mother is sad and crying all the time.

Tina is very ashamed of herself and the depression, and she isolates herself a lot in her home. She feels that others “would be better off without” her, and that she is “of no worth”. She practices to be open about her situation and the depression diagnosis to others, but she feels “small” when doing it. Tina has a lot of existential considerations. She speculates for instance, if she should remain married to her husband or if a divorce would do her good. Yet, she has decided not to take any momentous decisions in her current mental state of mind. The reader will in particular meet Tina in article 3.

Peter

The two interviews I conducted with Peter took place at the dining table in his apartment. He is 34 years old and lives in one of the bigger cities in Denmark. A picture of Peter’s deceased father hangs in a silver frame on the wall behind Peter’s chair. My gaze continuously catches the picture while Peter explains that the depression is triggered by the loss of his father who he was closely attached to. Peter is the only child and his mother lives in Iceland where Peter grew up. A new job that Peter did not like

was another contributing factor to the depression. Peter feels lonely, and he is frustrated that his friends either live far away or are too busy with their own lives to see him. Once in a while, he tries to go on dates with women he meets online but he has not had any luck with this yet. When I visit him the second time he has just recently acquired a cat, Alfred, who is running around and playing while we are talking. Peter appreciates the cat, but he is also afraid that he will become “a crazy cat person”, as he says.

Shortly after his father died, Peter went to see a psychologist who said that Peter did not have a depression but that he was grieving in a normal way. However, Peter started to suspect that he had a depression about a year after his father died, insofar as he had a lot of days where he just felt like “staying at home, drawing the curtains – and lying on the couch sleeping all day and not feeling like doing anything”. As he said “it’s natural to grieve but you shouldn’t weep every single day for a year and a half!”. Hence, about a year after his father’s death, Peter’s tears, isolation and inactivity were transformed into a depression diagnosis. Treatment in the form of medicine and therapy was initiated. Besides that, Peter tries to go on long bicycle tours now and then and to prepare healthy meals every day, insofar as he is overweight and would like to slim down. Yet, he finds it difficult to get these things done. He manages to do his full-time job. He has not considered a sick leave, insofar as he believes this would make him feel even more isolated than he already does. Peter has not told his mother about the diagnosis. Only two of his friends know about it.

I ask Peter, how he feels about getting a depression diagnosis. His answer has an ambivalent character to it. The diagnosis assures him that he is not a “chicken (“pivskid”)”. At the same time, he also experiences it as a kind of brand or stigma. But then it also makes him feel that he has done something actively to make things better. Fear also follows from the diagnosis, insofar as he speculates how long it is going to last. In Peter’s own words: “For how long am I going to take these pills. It is just this year or several years, the rest of my life or how is everything going to turn out?”

Hannah

Hannah is 30 years old and lives in an apartment in central Copenhagen with her long-term boyfriend. She used to be an ambitious career woman working many overtime hours, until she became ill and came on sick leave. She believes the depression to be triggered by stress because of overworking. Hence, her “resources were dried out” and the depression “could overtake her”, as she explains. In addition to that, she also connects the depression with unprocessed traumas from her childhood, more specifically a date rape when she was 13 years old. Being a vulnerable and sensitive person is another central explanation, Hannah uses when explaining why she became depressed. She finds a kind of comfort in finding the reasons to the depression “in how she has lived her life”, referring to existential considerations she now is having about her priorities, values and philosophy of life. This makes her believe that it is possible

for her to make changes and feel better. She considers for instance, to move into the county, and she dreams about working part time when starting a family in the near future.

In overall terms, Hannah experiences the depression diagnosis as positive, insofar as it has helped her to realize that she has to do something different in order to thrive. She also finds that the diagnosis legitimatizes her condition and that it was relieving to get the doctor's approval that her condition is severe and that it necessitates treatment. The diagnosis also provides an explanation of her distress that she can use towards both herself and important others.

When I met Hannah the first time, she was diagnosed with moderate depression. Meanwhile, the depression worsened into severe depression, and she started medical treatment. Initially, she did not want to take medication. However, her social worker pushed her to start so that the social worker could prove that Hannah was doing something actively to get better. Luckily, Hannah finds the medication helpful. She describes it as a "crutch" or as wearing "plaster" and experiences that the medicine makes her feel doped and it raises her mood. Furthermore, she recently got a dog, and she describes the dog as a kind of sunshine drug. She is also very pleased about psychological treatment, yoga, mindfulness and a course she follows for people in a similar situation as her through the municipality. The reader will in particular meet Hannah in article 2 and 3.

Bridget

Bridget is in the middle of forties and lives with her husband and two children in a town house close to Copenhagen. She experiences the depression as triggered by a crisis in her marriage, being a Highly Sensitive Person (HSP) and difficult working conditions. The term HSP is a category that refers to how some people are born with a specific sensitiveness that makes them more vulnerable than average (Aron, 1988). However, the concepts also entail positive associations such as creativity, empathy and a certain valuable depth. Thus, Bridget prefers this term to interpret her distress through rather than the depression label in which she finds unfruitful and subversive.

Before the diagnosis, Bridget was not able to sleep well for months, and she felt anxious most of the time. Eventually, things worsened so much that she felt a need to seek professional support. Hence, she went to see her general practitioner in order to be referred to therapy. According to Bridget's understanding of her suffering, it originates from nonmedical problems. Her approach stands in contrast to the medical approach she is meet with from the psychiatrist that diagnose her with recurrent depressions. Bridget insists on the significance of her life circumstances in triggering her agony, and she questions if it is correct to name her condition depression.

Bridget is an exception in my fieldwork, and it is unusual to have such a critical relation to the diagnosis, as Bridget has. However, her story is interesting to focus on,

insofar as it provides an insight into diagnostic processes that involve resistance against and ongoing struggles with a depression diagnosis. Bridget is the key figure in article 1, and the article gives an in-depth portrayal of Bridget, and her experiences of a depression diagnosis.

Yasmin

Yasmin is 25 years old and she believes she has been depressed since she was 15 years old. She did not get a depression diagnosis until recently at the medical clinic where I meet her. She had already diagnosed herself with depression on the Internet beforehand so in this way, she was not surprised to get an official diagnosis.

Yasmin believes the depression to be caused by a difficult and chaotic childhood with domestic violence, a mother who drank in periods and a younger brother who had suicidal thoughts when he was ten years old. She also believes genetics and biology play a part in the depression, insofar as she has a family history with depression and other psychiatric conditions. Her parents got divorced when she was 17 years old, and she does not have much contact with her father. Yasmin is convinced that her mother suffers from either borderline personality disorder, or that she has a narcissistic personality disorder. She had read about these conditions on the Internet and watched television programs about it, and she recognizes her mother in the diagnostic descriptions. Yasmin describes herself as “the only normal person” in the family.

Yasmin moved out from her childhood home and to a new city a year ago and since that, she has tried to find the courage to reach out for professional help. She has suicidal thoughts and sometimes she just “feels like disappearing in a heap of leaves”. Recently, she got kicked out from a project group at the university. A student counsellor advised her to take sick leave so eventually, she contacted her doctor with the aim of getting a medical statement to obtain the sick leave.

The doctor diagnosed her with severe depression. Yasmin found it “a great relief and a great pleasure” to get the diagnosis on paper, insofar as it confirms her own interpretation of her situation. The diagnosis creates some kind of order in the mess she is in. It gives an explanation and a vocabulary that she can understand her distressing experiences through. It also removes some of the guilt and bad conscience, she is experiencing, and it legitimizes that she is not able to do the things, she is supposed to do.

Currently, she is trying to find the energy to contact a psychologist in order to start up psychological therapy. Meanwhile, she is getting supportive conversations with her general practitioner. Yasmin would like to start up treatment with antidepressants but the doctor holds back and estimates that they should wait and see. Yasmin finds this annoying. Furthermore, she tries to do fitness on a weekly basis and to eat healthy. She does not share her struggles with any friends, insofar as she does not really have any. She finds comfort in praying to God.

Yasmin describes depression as “living in a bubble”, and as if “someone is sitting both inside and outside of me and cuts me up”. She also uses a metaphor of an old and slow computer with a bad processor and a slow internet connection to describe how she experiences her current mental state.

Irene

Irene is in the middle of the fifties and lives in a small apartment in a suburb close to Copenhagen. The white walls are decorated with several pictures of her grown up daughter. Irene describes the daughter as the most important in her life. I notice a couple of statues with white angels in the apartment as well. Irene is soon to move in with her boyfriend in a new apartment.

Irene has for several years suspected that she might suffer from depression before she finally got the diagnosis, five months before I met her. Before the diagnosis, she tells me that she often wondered what was wrong with her. She could not understand why she found it so difficult to be satisfied with her life that seemed perfect from the outside. Yet, despite the apparent perfection of her life, she did not feel content. The diagnosis gives an explanation to the distress, she has experienced for long periods since her teenage years. The diagnosis gives an explanation to why she has isolated herself the last year, and an explanation to why she has cancelled appointments after appointments because she found everything confusing. The diagnosis makes her think that there is not anything wrong with her, as she had been thinking for years, and that the problem is not to be found in that she has a wrong approach to life or something like that. Furthermore, she can also use the diagnosis as an explanation to her partner. In that way, she experiences the diagnosis as a relief.

As Hannah and Bridget, Irene also uses the term being a Highly Sensitive Person as an explanatory factor to why she suffers from depression. Moreover, she thinks that a dramatic and hard divorce has played a significant part along with the death of her parents which she lost within a relatively short period of time. The absence of a regular life partner is also a central aspect. She also struggles with low hemoglobin percentage and the fuzzy diagnosis of irritable colon.

Irene does not take antidepressants. She has tried it but she cannot tolerate it. She does not like psychologists. Instead she has great confidence in several kinds of alternative therapists with a holistic focus on mind and body. Irene thinks the depression will be a faithful travelling companion the rest of her life, and that she needs to learn to be aware of several small signals in order to hopefully avoid further depressions in the future.

Sarah

Sarah is 32 years old and lives with her husband and two daughters in a one-family house two kilometers from where she grew up. She explains the depression as triggered because of too huge ambitions when she was studying to become a nurse. Only

high grades were good enough for her. A father who never has taken part in her life, also plays a part. When she was working on her bachelor assignment, she started to fear that something was wrong with her heart, and she felt like she was about to get the flu just before the exam. Yet, she takes the examination and receives the highest grade possible. Two days after, she wakes up in the morning, and in her own words: “I felt as I have never felt before. I was like deeply, deeply sad and anxious – and stressed – and all sort of things at once [...] I couldn’t eat, I couldn’t do *anything*”.

Half a year passes where Sarah lies on the couch from morning till afternoon at her mother’s house, because she cannot stand to be alone. She is crying and feeling awful. She sees her general practitioner once a week and fills out a depression questionnaire each time that says severe depression. However, nothing really happens before she gets a new doctor that sees how serious her condition is. The new doctor refers her to psychiatric treatment. Eventually, things slowly start to change for the better. Sarah start up on psychological treatment and medication and a nurse visits her in her home on a daily basis. She also attends a course for people on sick leave that the municipality arranges. In the beginning she found it extremely difficult to attend the course. Eventually she appreciates being among people in a similar situation that “looked normal”, despite the depression diagnosis.

Sarah gets very negative associations from the depression diagnosis. She finds it very difficult to identify with the diagnosis and to think of herself “as one of those with depression” with all the negative associations she gets from it.

It is characteristic for Sarah that she fears the future because of the diagnosis, insofar as she had read that depressions can be recurrent. She finds it difficult to live with this fear and it influences how she lives her daily life, and how she imagines the future to unfold. Sarah believes that the only positive thing about the diagnosis is that the fear that follows from it works as a kind of catalyst for change. She tells that she lives her daily life much more cautiously now. She is less spontaneous and she takes better care of herself in the sense of keeping her bed times just as she eats healthy and exercises regularly. She and her husband have abandoned their dream about a third child, insofar as Sarah fears that the breastfeeding at night and sleep deprivation would cause a new depression.

It is remarkably how Sarah uses a *before* and *after* the depression. It makes her sad that things never will be as they used to be, and that she “cannot count on herself anymore”, as she puts it. She has become much more “melancholic” (“tungsindig”). She misses the person she used to be.

Leila

Leila is 29 years old and lives with her fiancé in a small house in a suburb of Copenhagen. She travels a lot with her work as a designer which she finds very anxiety-provoking, insofar as she several times have experienced to be hospitalized on these

trips abroad because she suffers from endometriosis. This disease gives her severe physical pains in long periods. This terrible illness plays a significant part in Leila's explanations for her depression. Another central explanation Leila gives to her depression is a difficult childhood with an unpredictable father that suffered from bipolar disorder. An abusive romantic relationship she had in her teenage years is another central element to Leila's distressing experiences. She emphasizes hereditary and biological factors as well, and thinks that depression also has something to do with a serotonin deficiency in her brain. In overall terms, Leila understands depression as caused by a complex interplay of environmental and biological and hereditary factors.

Even though Leila was given a depression diagnosis by her general practitioner when she was 22 years old, and eventually started antidepressant medication, psychological therapy and later group therapy, she refuses to understand herself as a person who is living under the description of depression. She finds it difficult to identify with the diagnosis, insofar as she for instance never has experienced to be unable to get out of bed in the morning. She has always worked hard, and gone ahead with her life, and she describes herself as ambitious and hard-working. Leila finds that the term depression has a negative sound to it, and she does not use the word to describe herself. She prefers to call herself "intense" or "passionate" instead, insofar as these words resonate better with the person she would like to be.

Leila uses a range of strategies to deal with her problems and her "uneven temper". Currently she is trying to quit the antidepressants she has taken for 7 years, because she wishes to become pregnant in the near future. Furthermore, she attends group therapy in a depression group at a psychiatric department (this was where I meet her). She also walks a dog and exercise on a weekly basis with her fiancé. The reader will in particular meet Leila in article 2.

Jürgen

After about 40 years of marriage, Jürgen's former wife suddenly came and asked for a divorce. She felt that they had grown apart, and she wanted to make something out of her life, while she was still able to. Just before his sixtieth birthday, Jürgen was caught off guard. He was completely unprepared, as he had not seen it coming. In the interview, he accounts for how he felt totally despondent. He did not feel like getting up in the morning. Everything was a struggle. Yet, he decided that he wanted to continue to go to work, no matter what. He recalls how he suddenly in the middle of the classes he was teaching, forgot the mathematical equations that he had taught for decades. He got negative evaluations from his students, that for instance depicted him as angry. Eventually, his former wife encouraged him to take a self-test on the Internet that said severe depression. Afterwards he thought it would be a good idea to see his doctor. The doctor did a similar test that also showed severe depression. The doctor persuaded Jürgen to start up a small dosage of antidepressant even though he did not feel like doing it because "it doesn't solve the problem", as he said. "It only puts the brake on the it". The outcome of the consultation with the doctor was that Jürgen was

referred to a psychiatrist who put him on antidepressants. Jürgen was also referred to a psychologist, and he found this therapy to be very helpful. He also started in a support group, driven by a patient's association. This was where I met Jürgen. At the time of the interview Jürgen did not take antidepressants anymore. He just stopped taking them from one day to the next without experiencing any consequences of it.

When I asked Jürgen to tell me about his history with depression he said: “it turned out to rather be a history about grief that resulted in a kind of depressive mental state rather than a history about depression. It is often very difficult to separate these two things. Also for doctors and psychiatrists. Is he grieving or is he depressed?” Attending the self-help group was what made him question his depression diagnosis and to reflect upon the boundaries between ordinary grief reactions and a depressive disorder necessitating treatment. He ponders over if his condition rather was to be understood as profound sorrow and helplessness because of his loss. Eventually, Jürgen concludes that it does not matter whether it is called the one thing or the other. The most important is, that he is feeling well again. That is what matters the most to him.

Jürgen reports that he did not experience that the diagnosis helped on its own but the sessions with the psychologist did, along with the medication and the meetings in the support group. Recently, Jürgen moved in with a new partner and has started a life with her. I visited him in their new home an hour from Copenhagen, and he seemed content with his new life.

Nanna

Nanna is 28 years old and lives by herself in a small studio in a small city in Jutland. She has a Persian cat, and the studio is filled with cat things. Small notes with messages to herself hang on the white walls here and there. On one of the notes she has written “Things I always forget”, followed by a line saying “life is great!”, and “there is nothing wrong with me. I’ve been injured”.

The most significant event Nanna subscribes to the depression is a sexual assault committed by a close relative when Nanna was in her early teenage years. She did not tell anyone about the assault until a few years ago. The assault taught her that “you cannot trust anyone” as she says, and that “I should be ashamed of myself and put myself away”.

Nanna depicts a feeling of being constantly behind others, which she furthermore believes to be a reason to the depression. She describes it the following way: “I think you get sick because you constantly feel you are behind. In points. I see on Facebook how many of my friends have a husband, children and a house at this time – And I’m just like, ouch! [...] I’ve been sitting like this (demonstrates a sunken body) while the others were out experiencing the world.” The long stagnation periods in Nanna’s life where she has been on sick leaves has made her feel that there is a lot of things she

has to catch up with compared with the life of other peers. In this way, Nanna feels out of synch with the surroundings.

Nanna was not surprised when she got a diagnosis of depression. Yet, when the diagnosis was noted in her medical record, she felt that she had become branded and marked. She did not like it at all. Later on, when she entered a course in the municipality and got a social worker, the word “mentally ill” was often mentioned. Nanna describes how she thought for herself, “I’m bloody not mentally ill! That’s not me. Because I thought about those people in a mental hospital. That’s not me!”. At the same time, she also felt that she had to accept her situation and hence also the diagnosis she had been given. The positive part of the diagnosis is on the other hand, according to Nanna, that it has helped her figure out how she should live her life in order to thrive. Yet, she finds the process way to slow and exhausting.

Nanna takes antidepressants, and she has gained ten kilos, since she started the treatment. She experiences a lot of difficult adverse effects such as difficulties sleeping and nightmares, and she wishes to stop the treatment as soon as possible. Nanna also attends some kind of alternative treatment with a therapist that she is very fond about. She underlines, that the therapist seems personally involved with her, insofar as she also gets emotionally affected by Nanna’s situation during the sessions. In this sense, Nanna finds the therapist “real”. This seems to be of great importance to Nanna.

CHAPTER 3. BACKGROUND ON DEPRESSION

Depression has a long and varied history and has existed in several versions since the classical period. In this section, I briefly engage with the changing conceptualizations of depression in a historical framework, from earlier medical thoughts on melancholia in ancient Greece, to the medieval and religious concept of *acedia*, to the nervous disorders in the eighteenth century, and finally to today's diagnostic and psychiatric understanding of depression. The purpose of this chapter is not to make a thorough historical exploration of how depression has evolved as a phenomenon as other researchers have done (Ehrenberg, 2010; Jackson, 1986; Lawlor, 2012). The aim is rather to explore in brief where the diagnosis of depression comes from by outlining some historical points of impact that have had led to the present in which a certain biomedical and diagnostic understanding of depression has become victorious. Exploring the predecessors of what we call depression today can exemplify the historical and cultural contingency of the various labels available to describe and interpret suffering through, as well as the universal character of the distress which the categories are supposed to designate.

I start with a brief historical portrayal of depression from its classical birth to the modern depression of today in which the development of the reigning Diagnostic and Statistical Manual of Mental Disorders (DSM) has played a significant part. I end by introducing the current diagnostic definition of depression, and the official guidelines on how to diagnose and treat depression in Denmark.

3.1. A SHORT HISTORY OF MELANCHOLIA

Before depression made its entry, melancholia was a widespread category through which to interpret feelings of sadness and dejection. Two of the most recognized historical books on this topic is first and foremost the English scholar Robert Burton's classic "The anatomy of melancholy" from the early 1600s and later the classic from 1986 of the psychiatrist and scholar of the history of psychiatry and medicine, Stanley W. Jackson. However, the reason why I primarily apply the excellent book, "From Melancholia to Prozac, a History of Depression" by Clark Lawlor (2012), professor of eighteenth-century English literature, in the following is that Lawlor illustrates the complexity of the concept of melancholia and the various meanings attached to the term regarding its physiology, motivation and cure in a thorough and very accessible manner.

Like depression today, melancholia has had a broad popular usage, vacillating between denoting "generally unusual or 'mad' behavior" (Lawlor, 2012: p.26) and a

serious and disabling physical and mental illness. Today melancholia has almost become an archaic term with no contemporary clout or resonance (Hammer, 2006: p.37; Petersen & Rønberg, 2015: p.224). However, the concept of melancholia is relevant to touch upon here, insofar as melancholia often is said to be depression's predecessor; this points to the similarities as well as the considerable differences between the two terms.

The concept of melancholia goes back to the ancient Greeks and the belief in the humoral theory of disease in which health and illness was thought as conditional on balances or imbalances in the four body humors: blood, phlegm, yellow and black bile. Each human was thought to have a certain dominant humor which determined one's personality type as either sanguine, phlegmatic, choleric, or melancholic. A person with a predominance of black bile was a melancholic person who was "inward looking, often intellectual, in the broadest sense of the term, possibly solitary in tendency" (Lawlor, 2012: p.29). This temperamental inclination could "tip over to a serious illness" (Lawlor, 2012: p.29), and melancholia was also regarded as a long-running mental illness with causeless fear and despondency, sometimes accompanied by hallucinations (which are absent from the diagnosis of depression today). Melancholia was thus believed to be the result of an excess of black bile (the humor causing general madness), to be restored through purging or bleeding (Lawlor, 2012: pp.26,31; Martin, 2007: p.16). In this way, melancholia had a physical basis, just as powerful emotional stimuli also were believed to trigger melancholia. Lawlor emphasizes that the physical basis of melancholia was quite different from the dominant discourse of depression as a single disease entity today, underlining how imbalances of the black bile could be caused by a wide range of factors such as unrequited love, changing seasons, and lifestyle factors such as "too much heavy meat", and "thick and dark wines" (Lawlor, 2012: p.36). Lawlor furthermore argues that everyone was different in their melancholy illness, referring to the broad category of melancholia, and the infinite variety of individual melancholia in comparison with the narrower concept of today's depression. At the same time, Lawlor reflects on how melancholic sufferers could "blame" the black bile for their agony in a way that might have been similar to how sufferers from depression can "blame" their lack of serotonin today (Lawlor, 2012: p.65), or at least they can use this image of depression to release them of some of the responsibility for their suffering and social failures, as I deal with in article 2.

Over the course of time, melancholia has also been regarded as a religious and moral disorder caused by devils and demons, and associated with guilt and sinful behavior (Ehrenberg, 2010: pp.23–24, Lawlor, 2012: p.32). The advent of Christianity, for example, brought with it *acedia*, a term that originated from Egyptian monks isolated in the desert in the fourth century, which "gave rise to a set of symptoms that included a nostalgia for previous lives and a hatred for the present monastic one, low mood, ennui, and general misery" (Lawlor, 2012: p.37). *Acedia* is thus to be understood within a Christian framework of fighting "worldly temptations of the devil and the sins of the flesh" (Lawlor, 2012: p.37). *Acedia* was a stigmatized condition and negatively framed as "a sin of idleness" and "sloth", to be cured through prayers, purges and drugs (Lawlor, 2012: p.38). *Acedia* faded at the time of the arrival of Protestantism,

and is today a relic from the Middle Ages. With the arrival of the new science in the eighteenth century, and the modern notion of depression as a disease stemming from organic (brain) malfunction (Lawlor, 2012: p.39), the old equation of mental illness and religion were slow to vanish, at least in the Western hemisphere of the world.

A melancholy of the nerves

The humors of classical thinking and the medical theory of melancholy as the product of black bile, were left by the Age of Enlightenment, and replaced by a “new melancholy of the nerves” (Lawlor, 2012: p.91). In the medical theories of nerve disorders, each person was thought to have a certain store of nerve force, and some people had a greater supply than others. Hence, in the nervous version, melancholia was regarded as caused by a defective nervous constitution, or by a nerve force which had not been managed carefully enough. The nervous system could be irritated and pushed into depression by, for instance, overwork, “whether it be study, literary and artistic creativity” (Lawlor, 2012: p.108), which led to a lowering of nervous energy and eventually to nervous exhaustion. Hence, melancholia was now caused by “excessive tension due to external circumstances” (Ehrenberg, 2010: p.26), implying that factors such as the pace of change, characteristic of the Victorian period during which nerve disorders were at their height, played a vital role in lowering a person’s nervous energy. Besides that, too much drinking, late hours, bad company and sexual activity (especially masturbation) were other factors that could provoke nerve disorders. Consequently, the treatment was based on trying to restore energy to the drained person (Lawlor, 2012: pp.105–109). Thus, the nervous version of melancholia was not a generalized disease either, but each person’s physical and psychological nervous constitution, as well as one’s life events, contributed to the individual outcome of the disorder (Lawlor, 2012: pp.111–112).

Professor Emerita of Philosophy, Jennifer Radden (2003) has discussed similarities and differences between melancholia and depression. Radden argues that feelings such as sadness, dejection, and despair are central to both melancholia and depression, in addition to the seeming lack of causal explanations. A considerable difference between melancholia and depression is that the category of melancholia is much more broadly defined in comparison with depression, and therefore contains conditions which would be categorized otherwise today. In this way, in melancholy “were as many flexible descriptions of individual life-course outcomes as diseases conceived of in terms of modern notions of specificity”, Rosenberg writes (2006: p.125). Melancholia is furthermore mainly a male condition, whereas more women are diagnosed with depression today. And while melancholia primarily was an upper-class phenomenon, depression cuts across barriers of class in contemporary times. Studies have even demonstrated a linear relation between causes of depression and psychosocial issues such as poverty, thus indicating that people from the lower classes are more vulnerable to depression (Brown & Harris, 1978; Sundhedsstyrelsen, 2007: p.24). Moreover, Radden (2003) underlines how depression is accompanied by a feeling of losing one’s self, as well as agonized self-criticism and self-hate, which was not associated with melancholia to the same degree. Melancholia was rather regarded as a

positive creative power, making the melancholic person able to craft something of brilliant character, which I will unfold in the following section.

3.2. THE MYTH OF THE MELANCHOLIC GENIUS

Through different historical epochs, from ancient Greece to the nineteenth century when depression gradually started to gain ground, Lawlor traces two competing and divergent versions of melancholy. The first one is a serious depressive form in which melancholia is portrayed as a grim curse leading to madness, and at worst, to suicide. Lawlor traces this negative version of melancholia back to Galen, physician to the emperor of Rome in the second century AD. The second version is a more positive type of melancholia that comes with a good cause in which a moderate portion of black bile (or nervous sensibility) is associated with heroism, genius, and a certain desirable sensibility. There is, in other words, a delicate balance to be maintained between the creative and genius effects of melancholia, and an over excess of black bile that turns attractive aspects of melancholia into madness. Lawlor traces this popular link (or “myth” as he writes) between melancholy and genius back to Aristotle who regarded “men of great ability” as melancholic (Lawlor, 2012: p.33). According to Aristotle, melancholia was a label held “as a badge of honor, the mark of” all truly outstanding men with creative and moral qualities” (quoted in Melechi 2003 in Jutel, 2011: p.26). In this version of melancholia, the black bile is not perceived as diseased but rather as beneficial, and melancholia is a desirable condition.

Lawlor describes in detail how these two versions of melancholia take distinctive forms during different historical periods. From the Renaissance discourse of the melancholic intellectual, in which too much thinking was assumed to cause melancholia, to the Romantic period, where the positive version of melancholia eventually peaked with the periods “valorization of a pleasurable sadness” (Lawlor, 2012:p.99), melancholia “becomes one with the artist, that tragic and sublime figure whose genius is on the level with her suffering”, as the French sociologist Alain Ehrenberg (2010) writes while simultaneously underscoring how melancholia, for the ordinary person, is a serious illness (p.26). However, nervous disorders became associated with a certain refined sensibility, rendering them fashionable disorders among the elite, for whom social and cultural advantages ensued from the condition (Lawlor, 2012: p.91). Men were, unsurprisingly, more disposed to nervous disorders than women “because they were ‘more exposed to numerous sources of cerebral excitement in the worry and turmoil of the world’” (Lee in Lawlor, 2012: p.108). Once more, it was the male, upper-class elite who was “the initial beneficiary of such elevated notions” (Lawlor, 2012: p.90), although there are examples of women with status and money who were able to exploit the old discourse of “melancholic creativity” and “the finer-nerved sensibility” (Lawlor, 2012: p.92).

Melancholia has, in other words, continuously been regarded as being “at the cross-roads of creative genius and madness” (Ehrenberg, 2010: p.xxx), and Lawlor argues

that this link persists up to the present day. Melancholia is no longer used in its grim form to denote a devastating illness; however, melancholy is still used today to designate milder forms of a kind of melancholic inclination or mood, Lawlor claims, although in a less widespread form (2012: pp.29, 42).

None of my informants have used the term melancholia to describe their depression⁹. Some have reported that the painful experiences with the illness have made them reassess their lives, which eventually has led to positive outcomes somehow over time, just as some feel that they have become better acquainted with themselves. In a similar way, the literature on qualitative studies on being diagnosed with depression, from time to time portrays a tendency to transform devastating illness experiences into something positive and profitable. A few studies report on how depression experiences have led to “personal growth”, or a certain acquired insightfulness (Karp, 2006: pp.244–247; Lewis, 1995). Experiencing a depression diagnosis can also be a kind of epiphany, “a difficult but ultimately ‘life-saving’ experience” (Kokanovic et al., 2013: p.385), that influences one’s views of the world and self in valuable ways. These more or less positive experiences of depression are nevertheless seldom present in the literature, just as they have been remarkably rare in my fieldwork. And importantly, this is not the same as embracing depression, or finding some kind of delight in it, similar to how Ehrenberg quotes Michelangelo for having said “my joy is melancholia” (Ehrenberg 2010: p.26), referring to the old notion of melancholia as a catalyst for creative art.

This brief summary points to a huge difference in the societal status of melancholia in earlier times and the contemporary status of depression. Today depression does not contain any of the fashionable and desirable aspects previously attached to melancholia and which, to some extent, are associated with other diagnoses such as bipolar disorder (Martin, 2007) and ADHD (Nielsen, 2016; Rønberg & Blæsberg, 2014). This is a topic I will return to later in chapter 6, where I also will engage further with the contemporary unattractiveness of depression, and relate it to the formative mutations of individuality that have occurred during the second half of the twentieth century (Ehrenberg, 2010).

In the following section, I will describe how diagnosis and the accompanying diagnostic language have come to play such a significant part in how we interpret suffering. I relate this to the development of the reigning diagnostic manual, the “Diagnostic and Statistical Manual of Mental Disorders” (DSM), and the larger social, technological, and cultural forces that impinged upon this.

⁹ However, a young male participant from a lecture I gave, made me aware that in certain artistic circles, for instance among musicians, or in the Emo subculture, the melancholy is still alive and well, and romanticized as a certain desirable creative force and profundity—an aspect that would be interesting to delve into further in future research.

3.3. PSYCHIATRY AND THE DIAGNOSTIC SYSTEMS

What we today regard as a mental disorder, manifested and institutionalized through the diagnostic manuals was, before psychiatry originated as a specialty, termed with broad generic descriptions such as “madness” and “insanity” (Martin, 2007: pp.5–6). When psychiatry came into existence, the specialists at that time, gradually started to subdivide madness into distinct mental disorders such as the German psychiatrist Emil Kraepelin’s “manic-depressive psychosis”, the Swiss psychiatrist, Eugen Bleuler’s “schizophrenia”, and not least the “neurosis”, a generic description for different minor mental disturbances, which later came to be widely distributed (Ehrenberg, 2010: p.49). In overall terms, there were far fewer categories available earlier to designate deviance and distress compared to today’s diagnostic expansion. Since the nineteenth century, during which psychiatry originated as a specialty, the discipline has tried to address deviance, emotional and behavioral matters, as well as “the imperfectly understood” (Rosenberg, 2006: p.124). Insofar as the discipline has always dealt with “a particularly sensitive and contingent subset of problems” (Rosenberg, 2006: p.124), its boundaries and domains have continuously been contested, fuzzy, and unclear, which the changeability of the DSM demonstrates.

The development of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published for the first time at the beginning of the 1950s by the American Psychiatric Association, was driven by an attempt to develop a better and more precise diagnostic terminology, and thus leave psychiatry’s “vague, complicated, [and] long-winded” (Balint in Jutel, 2011: p.22) descriptions of pathological states behind. The aspiration was to create a common language to discuss and define mental disorders, enabling systematic comparisons both nationally and internationally to be used in public health efforts. It was furthermore motivated by an attempt to qualify psychiatry to become more like its counter disciplines by providing more precise, and reliable categories, and in that way “convey status and legitimacy to the languishing psychiatry” (Jutel, 2011: pp.23, 32).

The first version of DSM was a slim volume published in 1952, wherein psychodynamic and psychoanalytical approaches to mental disorders, emphasizing contextual factors, abstract etiological theories, and non-linear causal explanations, were privileged (Jutel, 2011: p.31, Mayes & Horwitz, 2005). This paradigm also characterized DSM-II from 1968, in which depression, at this time a minor diagnosis, was described as a result of internal conflict and/or external circumstances the following way: “This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished passion” (American Psychiatric Association in Ringø, 2016: p.62).

In the 1970s, it became clear that the DSM was not cross-culturally reliable. Cases showed that the same patient could be diagnosed with, for instance, schizophrenia in America and with manic depression disorder in England (Kleinman & Good, 1985: p.5). In 1972, the US-UK Diagnostic Project furthermore showed that “the British diagnosed depression five times as much as the Americans” (Lawlor, 2012: p.166),

which was embarrassing as these results undermined the psychiatric profession. Simultaneously, other professions were interfering in psychiatry's area. Critics claimed that the discipline was medically unscientific, reflecting how psychiatry was (and still is) marginalized within the medical community. At the same time insurance companies and governments, providing financial reimbursement, were criticizing psychiatry for being too broad and imprecise in its approach to mental disorders. An attempt to improve diagnostic reliability by creating a "repertoire of tightly bounded, seemingly objective, and generally agreed-upon diagnostic categories based firmly on bio-pathological mechanisms" (Rosenberg, 2006: p.124), and a "struggle for professional status and direction" (Mayes & Horwitz, 2005: p.266), was thus part of the background to developing DSM-III.

The leading psychiatrist to coordinate this process was Robert Spitzer, a prominent psychiatrist at Columbia University, who used a Kraepelin-inspired framework as the guiding principle for the new classificatory model in DSM-III. Kraepelin was one of the first to perceive of mental disorders as characteristic somatic mechanisms with a biochemical or genetic substrate, equivalent to somatic diseases (Brinkmann, 2016: p.x; Lawlor, 2012: pp.136–142; Mayes & Horwitz, 2005: pp.259–260). Based on clinical observations of visible symptoms, he developed a classification system of mental disorders which later oriented Spitzer and his colleagues in the development of the DSM-III. In the case of depressive states, Kraepelin's version was quite different from the melancholic inspiration of earlier times. Kraepelin regarded patients suffering from depression, as "failures in professional life", and "they were despairing and had no 'fit' with their general social environment", as Lawlor writes (2012: p.138). Kraepelin did not, in other words, associate depression with genius or a valuable sensibility, and rather followed the Galenic heritage and his illness version of melancholia.

Until the introduction of the DSM-III, diagnosis only played a marginal role in psychiatric practice. With the implementation of the DSM-III, diagnosis quickly became the basis of the psychiatric discipline (Mayes & Horwitz, 2005: p.250). In overall terms, the publication of the DSM-III in 1980 marked what Allan V. Horwitz, professor of sociology, has called a *diagnostic* and biological turn in Western psychiatry (Horwitz, 2002). This means that an etiological and dynamic approach to mental disorders, inspired mainly by psychoanalytic theory, was left in favor of a symptom-based approach in which clusters of symptoms were thought to constitute underlying biological disorders to be treated with biological remedies (Brinkmann, 2016:p.11; Mayes & Horwitz, 2005; Svenaeus 2014)—an approach to mental disorders that has dominated since then in the revised successors of the DSM-III R in 1987, the DSM-IV from 1994 and also the DSM-5 in 2013. Overall, the DSM-III caused a revolution in psychiatry, just as it triggered a remarkable shift outside the psychiatric domain in society's view and management of mental illness (Horwitz, 2002; Mayes & Horwitz, 2005: pp.258, 264).

3.3.1. MENTAL ILLNESSES AS DISORDERS OF THE BRAIN

According to Charles Rosenberg, “the notion that diseases can and should be thought of as entities existing outside their unique manifestations in particular men and women” (Rosenberg, 2006: p.125), started to become culturally pervasive in the last third of the nineteenth century. Rosenberg uses the term “specific disease entities” to designate a historical time in which diseases must be (or at least appear to be) based on a specific and somatic disease model to find wide acceptance along with a widespread faith in the explanatory power of disease models. The paradigmatic turn in psychiatry thus mirrors a long-term trend in Western society toward “reductionist, somatic and disease-specific explanations of human feelings and behavior” (Rosenberg, 2006: p.122), a tendency that made its entry into the psychiatric disciplines to become institutionalized with the publication of the DSM-III.

We can furthermore understand the diagnostic and biological turn in psychiatry in the light of a tendency in which mental illnesses in general seem to acquire more legitimacy if they are proven to be disorders of the brain (Dumit, 2003; Fuchs, 2012; Martin, 2010: p.367; Rose, 2007: pp.216, 220; Rose & Abi-Rached, 2013). The time of the creation of the DSM-III was characterized by an optimistic faith that researchers within the neurosciences were able to prove that mental disorders were “real” conditions in the sense of being physical ailments, “no different from diabetes or cancer” (Rosenberg, 2006: pp.124–125). This scenario would make it less complicated to receive acknowledgment from others of a legitimate condition and to equal mental disorders with any other medical illness (Martin, 2010: p.367; Rose, 2007: pp.216, 220). The years following the DSM-III were thus characterized by extensive and costly research in the promising area of neuroscience in the hope of being able to identify the neurobiological basis for the DSM categories and to develop objective biomarkers (Mayes & Horwitz, 2005; Rose & Abi-Rached, 2013). This went along with the launch of the new antidepressants, SSRIs in the 1970s, which initiated the widespread use of psychopharmacological treatment (Hewitt et al., 2000; Trivelli, 2014), thus underlining the pharmaceutical industry’s part in marketing the tale about depression and other mental illnesses as brain disorders (Frances, 2013; Healy, 2004; Karp, 2006; Whitaker, 2010). The drive to identify the neurobiological basis for depression and other mental disorders has yielded few results. As the American psychiatrist, and chair of the task force of DSM-IV, Allen J. Frances critically points out: “Billions of research dollars have failed to produce convincing evidence that any mental disorder is a discrete entity with a unitary cause” (Frances in Brinkmann, 2016: p.27). Owing to Frances’ status and influential role in the revision of the DSM-IV, it is very notable how he later became very critical of the DSM-5, which he criticized for diagnostic inflation and over-diagnosis because of the manual’s basic structure (Frances, 2013).

Despite the lack of clinically validated biomarkers at this point, it is still a widespread perception that depression and other mental disorders are conditions “with a corporeal seat in the brain of the afflicted individual” (Rose & Abi-Rached, 2013: p.138. See also Brinkmann, 2016: p.65; Jenkins, 2015: pp.4–5; Rosenberg, 2006: p.132), even when neuropsychiatry is unable to link the precise anomalies in the brain with the

troubled individual. As David A. Karp (2006) writes, the mantra of chemical imbalance, repeated so many times, has become a “kind of unassailable cultural fact” (p.76). This cultural fact has nevertheless been challenged since the beginning of the twenty-first century (Lawlor, 2012: p.177), to which I return in chapter 6 and article 2.

Critics of the DSM-III have claimed that a diagnostic and biological approach to mental disorder has fostered a superficial diagnostic practice that eliminates personal, idiosyncratic and social characteristics of illness experiences, thus “being parochial, reductionist, overly simplistic, and adynamic” (Mayes & Horwitz, 2005: p.264; Ringø, 2016: p.65). This line of critique resonates with my informant Bridget’s resistance to understanding herself through depression lenses which I unfold in the first article. It is furthermore a critique to which I return in chapter 6.

In the next section I provide a short introduction to the psychiatric definition of depression in Denmark and the official recommendations for diagnosing and treating depression.

3.4. DEPRESSION TODAY: DIAGNOSTIC CRITERIA AND CLINICAL PRACTICE

Depression is listed in both the American DSM and in the European diagnostic manual, “The International Classification of Diseases” (ICD), published by the World Health Organization. ICD is the commonly used diagnostic classification standard in clinical settings in Denmark, and is therefore the primary manual I use in this section to describe the current diagnostic criteria for depression, in combination with the official guidelines on depression from the Danish Health Authority. The latest version is from 1994 (with several revisions since then) and is called ICD-10. ICD-11 is expected to be published and implemented in 2018. DSM and ICD look very alike, yet there are minor differences between the two, such as more subtypes of depression in the American version. However, the approach to diagnosing depression is more or less the same in the two manuals (Petersen, 2016; Sundhedsstyrelsen, 2007: p.20). The similarity between the two is furthermore mirrored in how the Danish Health Authority bases its clinical guidelines on ICD-10, at the same time as it continuously involves and refers to the DSM-IV.

In overall terms, depression is categorized as a mood disorder characterized by a fundamental disturbance or change in affect or elation. The exact causes of depression are still inadequately mapped and much discussed. According to the Danish Health Authority, depression, in overall terms, results from a complex interplay of biopsychosocial forces, implicating genetic as well as environmental matters (Sundhedsstyrelsen, 2007: pp.23–25). The term depression furthermore covers a wide range of cases from mild and passing conditions to recurrent and chronic conditions, as the Danish Health Authority writes (2007: p.41).

In ICD-10, depression is more specifically classified into either a “depressive episode” or “recurrent depressive disorder”, and is specified as either mild, moderate or severe. The manual also distinguishes between depression with or without psychotic symptoms. There are, furthermore, a few subgroups such as “dysthymia”, and a “melancholy-type of depression”, also called a “somatic syndrome”, which can be given as a supplement to the depression diagnosis¹⁰ (Sundhedsstyrelsen, 2007:p.22; WHO, 2007:pp.86–92).

The diagnosis is defined as a clinically recognizable set of symptoms that must be present almost every day within the last two weeks. The degree of difficulty of depression is defined by the number of present symptoms. It is a requirement that the patient meet at least two of the three core symptoms: 1) lowering of mood, 2) reduction of energy, and 3) a decrease in activity or increased fatigability.

Besides that, the patient is required to meet a number of the following accompanying symptoms:

- Low self-confidence/self-esteem
- Self-reproach/feeling of guilt
- Suicidal thoughts
- Thought difficulties or poor concentration
- Agitation/inhibition
- Disturbed sleep
- Change in appetite and weight change.

At least two core symptoms and two accompanying symptoms must be present to meet the criteria of a mild depression diagnosis; two core symptoms, at a minimum, and four accompanying symptoms must be present in order to make a moderate diagnosis, and finally all three core symptoms and at least five of the accompanying symptoms must be present to fulfill the criteria of diagnosis of severe depression.

3.4.1. CLINICAL PRACTICE AND CLINICAL REALITIES

In Denmark both general practitioners and psychiatrists can diagnose depression and prescribe antidepressant medication. Ninety percent of common mental disorders are treated in general practice, and most patients with depression are treated solely in primary care (Davidsen, 2009; Davidsen & Fosgerau, 2014). According to the clinical

¹⁰ The somatic syndrome is characterized by a loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido (Sundhedsstyrelsen, 2007: p.22). None of my informants talked about these subtypes but instead they just referred to their “depression”, just as they did not dwell on the degree of difficulty of their depression, unless I inquired into it.

guidelines for diagnosing depression provided by the Danish Health Authority, a diagnosis must be based on official monitoring instruments, and questionnaires on which the patient is required to rate herself on a scale with different options. The procedure is that depression first is diagnosed (often by the “major depression inventory”), after which the degree of difficulty is determined by another questionnaire (most often the “Hamilton Depression Rating Scale”) (Sundhedsstyrelsen, 2007: p.22).

Officially, it is recommended not to base a diagnosis on questionnaires alone, but to do an overall clinical assessment in which questionnaires are combined with thorough interviews with the patient, focusing on the patient’s psychiatric and somatic anamnesis, interviews with relatives, an assessment of comorbidity, and a somatic investigation as well (Sundhedsstyrelsen, 2007: pp.31–36). The choice of treatment depends on the severity of the depression diagnosis. In cases of mild depression, watchful waiting and supportive conversation are recommended. In cases of moderate and severe depression, a combination of medication and therapy is suggested. Besides that, the Danish Health Authority recommends a range of other options such as a healthy lifestyle, involvement of relatives, and psychoeducation (Sundhedsstyrelsen, 2007: p.43). However, the main weight is on medication and therapy in the official guidelines.

These are the official guidelines from the Danish Health Authority. The clinical realities in both general practice and psychiatry are often much more manifold, and sometimes depart from the official standards both regarding how the diagnostic process is performed, as well as the treatment initiated.

A part of the reason for this is most likely due to the inherent complexity of depression and the fact that “the depression diagnosis can contain many different symptom combinations”, as the Danish Health Authority writes, and thus “appear very clinically different” (2007: p.19, my translation). However, some of these discrepancies can furthermore be traced to different traditions at particular clinical settings, where different ideas operate about what depression is, and how depression diagnoses are to be made.

Medical specialist Annette Davidsen, and associate professor of the psychology of language, Christina Fosgerau (2014), have investigated how psychiatrists and general practitioners in Denmark have different understandings of what depression is, and different ways of carrying out diagnostic processes. In brief, general practitioners (GPs) “focus on the individual patients and their stories. They look at the bigger picture, of which the patient is a part, and describe the narrative complexity of the patient’s problems” (2014: p.7). The psychiatrists, on the other hand, focus on the specific symptoms, diagnoses, and treatment options. In practice this meant in Davidsen and Fosgerau’s study, that the GPs did not always have the symptom list or the questionnaire in front of them, but instead kept the scales at the back of their minds during consultations with patients. The psychiatrist, on the other hand, stressed the importance of the clinical interview and the clinical impression (Davidsen & Fosgerau, 2014: p.6).

In my own work, some of my informants report that the GP arrived at a depression diagnosis based on a questionnaire alone and a brief consultation. Shortly after, antidepressant medication was prescribed as the only treatment. At other times, the diagnostic process was much more thorough, and the treatment initiated was more diverse. From reading through the patients' journals in the depression group, and talking with the two psychotherapists at the psychotherapeutic clinic, I learned that it can be a collaborative negotiating process to find the right diagnosis. Health professionals (in this case psychiatrists, psychotherapists, and nurses) interact with the patient (and sometimes relatives) where they learn about their life stories, the anamnesis, and the patients' particular difficulties. A tentative working diagnosis is noted in the patient's journal after a meeting. Occasionally, the tentative diagnosis (and the patient) is taken up at a weekly medical congress where the diagnosis is discussed among the health professionals. At some point, the tentative diagnosis is presented for the patient with questions like 'how does this (diagnosis) sound to you?' It seems to be important to test whether the patient can recognize him- or herself in the symptoms in the diagnostic description in this particular clinical context, keeping in mind that the language of depression in the DSM is constructed on samples of depressive patients. This case is thus an example of a thorough diagnostic process performed at several levels and with several actors, in line with the official guidelines. This thorough diagnostic process stands in contrast to how Bridget experienced her diagnostic process as superficial, upon which I elaborate in article 1.

Another example from my fieldwork illustrates how different images about what depression is and how it should be treated operate among health professionals, in line with Davidsen and Fosgerau's (2014) study. At the psychotherapeutic clinic, I noticed how the two psychotherapists talked negatively about the "biologically oriented building" across from their office. They criticized them for being too occupied with diagnoses and chemical imbalances in contrast to their own approach. From following the sessions in the depression group, I gained concrete insight into how a certain psychodynamic tradition seemed to operate at this particular clinic, which might not be so surprising given the psychotherapeutic launch pad. In practice, this was expressed by how the therapists focused a lot on the patient's life history and difficult life events both in the diagnostic process and in the way they carried out group therapy. When preparing the patient for group therapy, they had in-depth conversations with the patient during which he or she told about his or her life history and current problems. As part of the preparation for the group therapy, the psychotherapists narrated a one-page document with a brief summary of the patient's current problems, a section on the patient's background and life history, and lastly, a title called "focus of attention", where concrete focuses were formulated with which the patient was supposed to work during the group therapy. I was furthermore surprised by how seldom they mentioned the word depression or the diagnosis during these sessions. Instead, they focused on the patient's difficult life events, their urgent problems, and problematic interpersonal relations.

These findings resonate with the work of the psychiatrist and medical anthropologist, Arthur Kleinman, on psychiatric diagnoses (1988a). Kleinman's point of departure is

his work in China and America, in which he collaborated with professionals with different cultural backgrounds and orientations on the causes and characteristics of the patient's suffering. Kleinman describes how these different circumstances made them differ in the diagnoses they found it suitable to give. Against this background, Kleinman argues, interpretations of symptoms in clinical settings depend on a range of social factors, such as clinical specialty, institutional setting, distinctive background of the psychiatrist, as well as the actual experiences of the patient. All these factors influence how clinicians perform the diagnostic process, how they interpret a patient's illness experiences, and the diagnostic categories they eventually decide to apply (Kleinman, 1988a: p.7). Eventually, it also influences how the patient interprets and receives the diagnosis given.

3.5. CONCLUDING REMARKS

The brief history of melancholia and depression in this chapter illustrates the complexity of depression as well as the changeability regarding causative theories, notions about cures, and societal status. In this way, the changing conceptualizations depict how the diagnosis of depression is historically and culturally situated, and influenced by sociopolitical factors as several researchers have emphasized. Most striking is the difference in the respective societal status of melancholia as a somehow fashionable condition, which stands in a remarkable contrast to the contemporary unattractiveness of depression. In article 1, I analyze the low societal status of depression as an important factor among many, as to why some diagnosed persons find it difficult to subscribe to the depression diagnosis, and thus initially refuse to be a person who lives under the description of depression. A historical examination furthermore underlines the consistency in some of the feelings and conditions that the different terms are meant to capture. The widespread use of metaphors such as darkness and shadows, for instance, which seems to run through history (Lawlor, 2012: pp.27–28), indicate the universal character of the agony that the changing categories are supposed to capture.

Several researchers have rightly criticized psychiatric diagnoses and the diagnostic system for being too one-sided and reductionist because of the hegemonic and uniform way of framing depression as a disorder of the brain to be medicated. However, the empirical realities are much more nuanced and multifaceted. My informants living under the description of depression not only understand depression as a brain disorder to be medicated, but rather combine a range of different factors in the ways they understand the causes of their depression, and in the variety of ways they try to overcome depression. My findings likewise indicate that health professionals also perceive depression as a complex phenomenon with many causations and a range of treatments, while others follow a more stringent biomedical approach to depression.

This hints at a discrepancy between the critical literature and the more multifaceted empirical realities. More specifically, there seems to be a discrepancy between biomedical accounts of depression and a quest for contextualized explanations among both sufferers of depression and health professionals working with depression. In this thesis, my ambition is to nuance some of these debates, which at times seem to be too simplifying and bombastic. My intention with the articles is to illustrate the pluralism in the various explanatory factors behind depression and experiences of depression, as well as the variety of ways of interpreting, using, and living under the description of the wide-ranging category of depression in everyday life.

CHAPTER 4. THEORETICAL BACKGROUND – STUDYING EXPERIENCES OF DEPRESSION

Experience is a central concept in this dissertation, insofar as I am exploring the complex experiences of what we call depression in everyday life, the multifaceted and ambiguous experiences of getting a depression diagnosis, and the in-depth processes involved in learning to live under the description of depression. Thus, I find it necessary to outline my approach to experience in the thesis, and place it within the anthropology of experience; I start with this. Afterwards, I outline how illness experiences are approached within medical anthropology, as well as literature on the dialectical relationship between cultural categories and experiences which has informed my thinking. Subsequently, I introduce the phenomenology of depression along with a review of phenomenological themes that the qualitative literature on depression experiences has depicted.

The following is not meant to provide a thorough review of the different approaches to experience in anthropology and philosophy. The purpose is rather to outline the traditions that have informed my specific approach to experience in the thesis, which mainly stems from anthropology's long phenomenologically inspired tradition of considering the meaning individuals attribute to illness experiences, as well as the broader macrosocial processes that impinge on this.

4.1. AN ANTHROPOLOGY OF EXPERIENCE

“Whatever else an anthropology of experience might be, it is clear that it is, like experience as such, abundant, multiform, and a bit out-of-hand. Wherever we are, it is not at the gates of paradigm-land” (Geertz in Willen & Seeman, 2012: p.16).

Since the mid-1980s, experience, as a focus of research, has flourished within the discipline of anthropology. The turn to experience stemmed from the number of anthropologists searching for alternatives to the discipline's central concerns about structural relations, discourses, symbolic meanings, kinship structures, and political systems. Many anthropologists found that the main ways of exploring these areas of focus estranged and reduced individuals to roles, functions, and performers of rituals who neglected “the everyday experiences, contingencies, and dilemmas that weigh so heavily on people's lives” (Desjarlais & Throop, 2011: p.92). Hence, anthropologists started to direct attention to “the lived complexity of experience” (Jackson, 1996: p.8), using mainly a phenomenologically inspired framework. More specifically, anthropologists started to explore how people experience, sense, and live everyday lives in

different social and cultural settings, centered around various empirical questions (Desjarlais & Throop, 2011; Gammeltoft, 2003: p.273; Good et al., 1992; Kleinman, 1988b; Kleinman & Kleinman, 1991; Lock, 2001; Willen & Seeman, 2012; Whyte, 1995).

Despite its popularity, the concept of experience is controversial and much discussed within anthropology. The anthropology of experience does not, in other words, lend itself “to easy definition as a singular or unified theoretical paradigm” (Willen & Seeman, 2012: p.11). Different schools study experience with distinctive starting points, for instance, with a mainly phenomenological or psychoanalytical foundation. Despite internal differences and disputes, the branches of anthropology that deal with experience all share some of the same thematic and methodological foci. First of all, they all hold that “a robust engagement with experience in its embodied, sociocultural, political, and—crucially—interpersonal dimensions” (Willen & Seeman, 2012: p.1) is decisive in providing an adequate account of human being-in-the-world. Experience is furthermore approached as “situated within relationships and between persons”, as Jackson writes (1996: p.26). Hence, in contrast to more essentialist approaches to experience, the anthropology of experience stresses the interrelated dimensions of experience. Studies of experience are also likely to “confront the unruliness of human experience head on, including the everyday circumstances into which people are thrown as well as their efforts to inhabit, resist, and transform the palpable realities they inhabit” (Willen & Seeman, 2012: p.16). That means that anthropologists who study experience are attentive to “the indeterminate and ambiguous character of everyday life” (Desjarlais & Throop, 2011: p.92). Finally, the anthropology of experience is concerned with “both particular situations and the common threads of existence that weave through all our lives” (Desjarlais & Throop, 2011:p.97)¹¹.

In this thesis, I am mainly inspired by the branch of phenomenological anthropology, associated in particular with anthropologist Michael Jackson. In 1996, Jackson edited an influential anthology entitled, “Things as They Are. New Directions in Phenomenological Anthropology”, which outlined some general guidelines for a phenomenological anthropology. Simply put, “phenomenology is the scientific study of experience”, as Jackson writes (1996: p.2). More specifically, phenomenology is the study of phenomena “as they appear to the consciousness of an individual or a group of people”, that is, the study of lived experience (Desjarlais & Throop, 2011: p.88). Phenomenological anthropology is thus concerned with the world as it is experienced from a first-person perspective. In this way, phenomenological anthropology gives priority to lived experience over, for instance, theoretical knowledge. It also attends to “the abundance and plentitude of life” (Jackson, 1996: p.7), and to the “at times

¹¹ A parallel development took place within the sociological discipline, where a turn also occurred from a predominance of research based on structural functionalism to a flourishing everyday sociology based on experience-near accounts (see, for instance, Hviid & Kristiansen, 2005; Karp, 1996).

ambiguous, and deeply ambivalent realities of human existence” (Desjarlais & Throop, 2011: p.93), by detailed and in-depth descriptions of lived reality.

A central concept within phenomenological anthropology is “embodiment”, following the tradition of especially Merleau-Ponty (2012 [1945]). The large focus on embodied experience stems from a dissatisfaction with the Cartesian split between subject and object where the mind is perceived as “the locus of subjectivity”, and the body is treated as, “a physical object that the mind has to move, manipulate, or bestow meaning upon” (Jackson, 1996: p.31). In contrast to this viewpoint, Merleau-Ponty argues that human beings are primarily bodily beings, implying that, “consciousness [...] is in the first place not a matter of ‘I think that’ but of ‘I can’” (Merleau-Ponty in Jackson, 1996: p.31). The concept of embodiment thus refers to the lived body as the primary domain of experience.

In this thesis, I am inspired by the broad understanding of experience within the anthropological discipline, and I follow the tradition by situating experiences of what we call depression between the microsocial context of lived experience in everyday life and broader macrosocial processes. In this way, I approach experiences of depression, as intersubjectively and intercorporeally embedded, as well as informed by cultural and social discourses, political and economic tendencies, and the host of cultural categories available in a given culture. This entails that I continuously move between particular situations and unique life stories in my fieldwork, the “common threads of existence that weave through all our lives” (Desjarlais & Throop, 2011: p.97) and larger macrosocial tendencies.

4.2. SUFFERING AND ILLNESS EXPERIENCES IN MEDICAL ANTHROPOLOGY

In line with the experience-near currents in anthropology, medical anthropologists began to search for room for the suffering of individuals, as well as the shared suffering of social groups, in the 1980s. This was to a large degree meant as both a critique of, and an alternative to, the “largely experience-distant worlds of both biomedical and professional social science discourse” (Willen & Seeman, 2012: p.8). Medical anthropology has a long tradition of critiquing psychiatry and biomedicine for being too experience-distant, and thus reducing “lived experience to a set of narrow professional categories”, and for shutting “down possibilities for broader understanding of human suffering and its sources” (Willen & Seeman, 2012: p.9; see also Csordas, 2014; Good et al., 1992; Jenkins, 2015; Kleinman, 1988a; Martin, 2007; Schepher-Hughes & Lock, 1987). Acknowledging the complex relationship between “neurobiological and social psychological processes”, medical anthropologists criticize reductionist biological terminology for “distorting in the most fundamental way what pain are, for that matter, experience per se is about” (Good et al., 1992: p.9). A similar reductionism is applied to brain-based explanations of mental illness which “excludes core pathology that exists in sites and sources that are social, behavioral, and economic”, as Jenkins writes (2015: pp.4–5, see also Dumit, 2003; Martin, 2007, 2010). These points of criticism

address a discrepancy between the everyday world of illness experiences and biomedical research and practice.

A well-known terminology in that respect is Kleinman's distinction between "illness" and "disease" which is often used to analyze the relation between illness experiences, and the biomedical categories available to describe them. Illness refers to the patient's personal experiences, perceptions, and expressions of sickness. Disease, on the other hand, refers to how practitioners recast illness "in terms of their theoretical models of pathology", addressing the gap between professional and lay interpretations of illness (Kleinman, 1988a: p.7, 1988b). This distinction can be analytically valuable. In practice, however, a person's lived experiences and the cultural categories placed on that experience are mutually constitutive and intertwined, as Kleinman also underlines. We are, in other words, as Rosenberg (2002) tellingly writes "never illness or disease but, rather, always their sum in the world of day-to-day experience" (p.258). In like manner, philosopher Ian Hacking argues that cultural categories provide a vocabulary and a framework through which people can interpret experiences and, in this way, diagnoses are "making up people" by influencing how they understand themselves as human beings. On the other side, the diagnostic categories themselves are also shaped by how those who are diagnosed enact and express the suffering designated by the categories. Hacking terms this dynamic and reciprocal relationship between suffering individuals and diagnostic categories "the looping effect of human kinds" (Hacking, 2007). In this way, he also points to the impossibility of separating illness experiences from social influence and personal perception.

The study of illness experiences gives priority to the particular and the subjective content of how illness is "lived through by the patient rather than conceptualized and defined by medical science" (Jackson, 1996: p.6). "Pain is always lived as a particular kind of human experience", Good and colleagues write (1992: p.10), emphasizing how suffering has different meaning for individuals. Thus, anthropologists who study experiences attend to the "peculiar qualities of the sting and throb of pain affecting a particular person—with a unique story, living in a certain community and historical period, and above all with fears, longings, aspirations" (Good et al., 1992: p.2). Furthermore, medical anthropologists target the intersubjective dimensions of suffering, and underline how illness experiences not only affect the afflicted individual but also intimate relations. This again, is contrary to biomedicine and diagnosis tendency to focus one-sidedly on illness as an agent that resides in the individual alone (Good et al., 1992: p.9).

In article 1, I follow medical anthropology's long tradition for criticizing biomedicine for being reductionist, and the cultural categories of mental illness, in this case the depression diagnosis' inability to sufficiently capture and depict the complexity of lived illness experiences. I do this by portraying my informant Bridget's hard-fought struggle to resist understanding her pain through the lens of a depression diagnosis.

As already mentioned, a central debate within medical anthropology is the dialectical relationship between culture and experience. Cultural categories have great force in

reworking and reshaping experiences. They influence both “modes of reasoning about pain, its sources and treatment”, as Good and colleagues write, just as they “contribute, subtly and yet with force, to the building of personal perception and experience” (1992: pp.18–19). In the case of mental illness, anthropologist Janis H. Jenkins argues that cultural conceptions of mental illness play a significant role in how illness is experienced and treated from onset to recovery (Jenkins, 2015: p.18). She writes that “as a matter of lived experience there is no such thing as individual pathology” (2015: p.3), highlighting how lived experiences always are a culturally shaped phenomenon. Thus, we must be attentive to the social, historical, and cultural meanings of illness, the cultural categories available to describe them, “and the shaping of cultural expectations of persons in relation to gender, mental, and political status” (Jenkins, 2015: p.3). In article 2, I take cultural categories in the form of metaphors, images, and sounds of depression, as a starting point to analyze how people relate to the depression diagnosis in a complex range of ways.

The emphasis on the importance of culture to experience resembles the writings of Clifford Geertz, who was one of the first anthropologists to claim that no human emotions or feelings are “ever free of cultural shaping and cultural meaning” (Scheper-Hughes & Lock, 1987: p.28). The more extreme version of this statement is that “without culture we would simply not know how to feel” (Scheper-Hughes & Lock, 1987: p.28). This is a radical standpoint that tends towards refusing and neglecting biological dimensions of our existence. In this thesis, I rather follow the more nuanced tradition in medical anthropology of understanding experiences as constituted by a complicated interplay of biopsychosocial forces (Jenkins, 2015: p.2; Kleinman & Kleinman, 2007; Martin, 2007; Nielsen 2016). At the same time, I am critical of how conceptualizations of depression and other mental disorders are predominantly shaped by biomedical discourses and framed as disorders of the brain, in present-day diagnostic cultures. However, a central argument in the thesis is that the incorporation of the depression diagnosis into the personal lives of the afflicted happens in a variety of ways, pointing to a creativity and flexibility in how people relate to a diagnosis in everyday life in the context of diagnostic cultures.

4.3. QUALITATIVE STUDIES ON EXPERIENCES OF DEPRESSION

In making a review of relevant articles on qualitative studies on experiences of depression, it is necessary to be selective because of the wide range of literature covering this topic. For instance, depression in primary care, including doctor-patient’s relationships (see, for instance, Davidsen, 2009; Davidsen & Fosgerau, 2014, 2015), depression and recovery (Fullagar & O’Brien, 2012), experiences with antidepressant medication and the ambivalence of taking it (Karp, 1993, 2006; Trivelli, 2014), and the relations between depression, gender and power (Jack, 1991; Smith, 1999; Valkonen & Hänninen, 2012). In the following, I have chosen to review qualitative studies dealing with depression experiences centered around three different themes. First, I

review phenomenological work on depression based primarily on the work of phenomenological philosophers insofar as article 3 is mainly based on this literature. Secondly, I review studies that explore experiences with antidepressant medication and the ambivalence of taking it insofar as I touch on this topic in all three articles. Finally, I depict studies investigating experiences of depression in relation to gender and power, and I consider in brief what an analysis could have looked like if I had taken a gendered perspective on depression.

4.3.1. THE PHENOMENOLOGY OF DEPRESSION

One central phenomenological point is that human beings move through life and follow a specific rhythm of movement in our being in the world, in which we feel comfortably immersed in a world that is shared with others (Ratcliffe, 2015: p.15). We are, in other words, normally tuned in to our way of relating to and being in the world, and following a rhythm where body, self, temporality and environment are tuned to a common chord (Fuchs, 2013). Yet, experiences of depression are characterized by a fundamental disturbance in our being, leading to painful experiences of being detuned, and agonizingly out of synch.

In 2015 the philosopher Matthew Ratcliffe published “Experiences of Depression. A Study in Phenomenology” in which he sets out to develop a phenomenology of depression. Ratcliffe’s work is based on readings of phenomenological philosophers, published depression memoirs, and an Internet questionnaire conducted in 2011 with colleagues (Ratcliffe, 2015: pp.26–27). Ratcliffe’s point of departure is that “human experiences incorporate an ordinarily pre-reflective sense of ‘belonging’ to a shared world” (Ratcliffe, 2015: p.2). Ratcliffe follows Husserl in claiming that in ordinary perception we experience a range of possibilities as integral to the world. Yet, depression involves a change in how the person experiences and relates to the world, and therefore the horizon of possibilities becomes limited. Central to Ratcliffe’s argument is that depression involves a change in, or a shift in, what he calls “existential feelings”. Existential feelings are a kind of “background sense of belonging to the world” (Ratcliffe, 2015: p.41) and depression is, cut to the bone, a disturbance in existential feelings or an existential change that a person experiences to varying degrees. As a part of this overall transformation of the way of being in the world, body, temporality, and sense of self are experienced differently as well. Depression is furthermore about a range of other phenomenological themes such as guilty feelings, loss of hope, isolation, withdrawal, and a sense of a profound disconnection from the world, self, body, and others. These themes are inextricable aspects of the shift in existential feeling or existential change in depression, Ratcliffe argues.

One central theme that the phenomenology of depression depicts is bodily experiences of depression. Philosopher Havi Carel argues (2013), that “bodily certainty” is a fundamental aspect of human experience, referring to how we normally feel confident that our bodies function similar to the ways they have functioned in the past (p.148). A powerful faith underlines, in other words, our relationships with our bodies. Yet, in

cases of depression, this certainty breaks down and is replaced by “bodily doubt, that leads to a fundamental disruption of one’s sense of being in the world” (Carel, 2013: p.150). In the words of van den Berg, “the healthy person is allowed to *be* his body and he makes use of this right eagerly; he *is* his body. Illness disturbs this assimilation. Man’s body becomes foreign to him” (van den Berg in Ratcliffe, 2015: p.79). What was previously taken for granted becomes conspicuous in illness experiences (see also Carel, 2013; Fuchs, 2005a, 2013, 2014; Good et al., 1992; Leder, 1990; Ratcliffe, 2012: p.116). As Trivelli (2014) writes, in her autoethnographic account of depression, “the body makes its call. The body aches, in and beyond any *discourse* on ‘depression’” (p.152), referring to how depression fundamentally is experienced as a bodily condition in which the body is experienced as a foreign, alienated entity that takes control over the depressed individual. One of Carel’s central arguments is that bodily doubt “leaves a permanent mark on the person experiencing it”, leading to a different way of being-in-the-world, as a consequence of depression (2013: p.152). In article 3, I engage further with the theme of depression and embodiment. More specifically, I portray depression as an out-of-tune embodiment characterized by a fundamental disturbance of bodily experiences and loss of bodily resonance.

As human beings we are also temporal beings with a sense of continuity, and with a sense of direction and movement towards the future (Fuchs, 2001: p.180). Normally, we do not notice time; we just live in it. However, temporal being is too disturbed in the awful midst of depression. Time is suddenly noticed as being painfully out of synch, along with a block towards the future and a feeling of being stagnated or stuck (Fuchs, 2001, 2005b; Ratcliffe, 2012, 2015).

Fuchs (2005b) applies a distinction between “implicit temporality” and “explicit temporality” to depict this temporal disturbance in depression. Implicit temporality, refers to how time is pre-reflectively lived, for instance when a person is engaged in activities and thus, does not notice time. In these situations, time disappears from our attention and we are in flow. Hence, the future is present as something we implicitly progress towards. Explicit temporality, on the other hand, refers to how time is consciously experienced. The concept is linked with suffering and denotes how time become conspicuous in a like manner as the body becomes conspicuous in cases of illness. Fuchs describes how the depressed person “lives time no longer as his own: Instead it comes upon him in front and overrides him” (2001: p.180). A disturbing disharmony disrupts one’s being-in-the-world, and time does not work on one’s side. Thus, both the body and temporality can fall out of their implicit condition where the automatic coherence with the world is lost, and the person feels profoundly out of synch (Fuchs, 2005b). In this way, time and body are linked, and both are made explicit and conspicuous in experiences of depression.

Our temporal experience also contains intersubjective dimensions, similar to how we also are intercorporeally embedded (Fuchs, 2013; Fuchs & Koch, 2014). According to Fuchs, most of us have a feeling of being in accord with the time of others. We live, in other words, in the same intersubjective time, where we share a common world-time with others. We are thus temporally synchronized with the social world (Fuchs,

2001: p.181). Thus, temporal experiences of depression are about being out of synch with social time, that is, the social world with certain normative expectations about how a person is supposed to act and be at a certain stage in life.

Finally, experiences of depression are also about being disconnected or out of synch with the self, where it feels like losing oneself, or as if the self has somehow disappeared, as Karp portrays in an interview study (1996). Along similar lines, several of my informants describe how they “have lost themselves”, “don’t know who they are anymore”, and they express wishes for “getting back to themselves”. The accounts in my fieldwork are, in other words, filled with portrayals of a before and after depression, and of altered self-images.

The phenomenological themes I have depicted in this section are all common in my fieldwork, and I use phenomenological work on depression as a frame of reference in all three articles. However, in contrast to Ratcliffe and other philosophers’ phenomenological work on depression, my research is mainly rooted in ethnographic research and less in philosophical reasoning.¹² This gives a different starting point and certain advantages. First of all, interviews give the opportunity to ask follow-up questions and to challenge and revise one’s interpretations, as Ratcliffe mentions himself (2015: p.30). Furthermore, fieldwork allows the ethnographer to spend time with people suffering from depression, which offers certain valuable insights into experiences of depression that are qualitatively different from those of philosophical reasoning alone, as touched upon in chapter 2. In article 3, I particularly use these characteristic ethnographic insights to provide a portrayal of depression as an out-of-tune embodiment. More specifically, I use my own body as “an instrument of resonance” (Svenaesus, 2014) to depict what my informants were telling and showing me in terms of depression as loss of resonance and bodily doubt. In this way, article 3 develops further phenomenological research on depression by fleshing out how depression is experienced in everyday life.

4.3.2 EXPERIENCES OF ANTIDEPRESSANTS

Antidepressants are described as being used at high levels worldwide, and they are one of the most widespread ways of treating depression (Skovlund et al., 2017). At the same time, antidepressants are a contested terrain in which the medication sometimes is presented as an effective strategy to treat depression, and at other times, concerns about overprescription, difficult side effects, and misuse of the medication, dominate (Gibson et al., 2016: p.2; Ridge et al., 2015).

One of the starting points in investigations of the lived experience of those taking

¹² In chapter 5 I review qualitative studies that examine experiences of depression and diagnosis processes in a similar way as I do. Characteristic of these studies are, compared to my Ph.D.-project, that they are mainly based on interviews and less on participant observation.

antidepressants is that psychotropic pharmaceuticals are qualitatively different from other kinds of medication insofar as the purpose of taking antidepressants is to transform people's mood, perceptions, and feelings (Karp, 2006: p.12, Ehrenberg, 2010: p.6). This can lead to difficult questions of personhood and self. Karp analyzes the act of taking antidepressants as a "life-altering process of self-transformation" (2006: p.13), that influences the sense of self profoundly. This finding resembles how several studies have depicted the process of receiving a diagnosis as an event that touches on the sense of self and identity profoundly, as I depict in further detail in chapter 5.

Overall, qualitative studies that deal with the meanings antidepressants hold in people's lives accentuate the diversity in the experience of taking them, pointing to both positive, negative, as well as changing and ambivalent experiences (Gibson et al., 2016; Karp, 1993, 2006; Kokanovic et al., 2013; Petersen, 2017; Trivelli, 2014).

Based on 50 interviews with persons who use antidepressants in America, Karp reports that the account he heard the most in his work was an ambivalence toward the medication, ranging from a reluctance to rely on the medication, a process of moving from one drug or dose to yet another, and uncertainty about the efficacy of the medication (2006: p.21). Sometimes, antidepressants are experienced as relieving suffering in Karp's research, while at other times people are uncomfortable with taking the medication because it makes them feel less like themselves (Karp, 2006: p.13). This ambivalence is similar to the work of psychiatrist Peter Kramer who found that some of his patients reported that antidepressants had finally made them able to become themselves, while others experienced that they had become someone else because of the medication (Kramer 1994).

Based on interviews with antidepressant users in the United Kingdom and Australia, Ridge and colleagues (2015) identify a current quandary of legitimacy regarding antidepressants and the depression diagnosis. They analyze a precariousness of the legitimacy of pharmaceutical treatment and argue that antidepressants are publicly contested around debates on "the mixed fortunes of antidepressants", referring to disputes about the efficacy of antidepressants, claims of illegitimacy, and their potentially negative impact on personhood. Insofar as people are exposed to wider community debates on antidepressants, they investigate how antidepressant users experience taking the medication, viewed in light of the medicine's ambiguous reputation which shapes how the use of antidepressants is experienced.

In line with other studies, Ridge and colleagues identify a range of different and ambivalent experiences surrounding the use of the medication. First of all, positive experiences of taking the medication are reported in the study in contrast to the bad reputation antidepressants have publicly (Ridge et al., 2015: p.56). More specifically, antidepressants are experienced as giving access to part of the self which is experienced as more "authentic", referring to how people can experience medication as completing them as persons or as making them more like themselves on a positive note. This stands in contrast to how Karp's (2006) study reported that people can feel less like themselves as a consequence of the medication. Furthermore, some interviewees

thought they were using a “pseudo-illicit” rather than taking “genuine treatment for a medical condition” (Ridge et al., 2015: p.56), which resembles those connected with the illegitimacy of the drugs. Moreover, being an antidepressant user can negatively affect how people see themselves, “suggesting personal weakness” (Ridge et al., 2015: p.56). This goes along with reservations about being open about the consumption of the medication, pointing to the stigma attached to mental illness and pharmaceutical treatment. Finally, others try to resist the illegitimacy by overemphasizing their own positive experiences from taking the medication, and in this way, they position themselves as “proud ‘pill poppers’” (Ridge et al., 2015: p.57), along similar lines to how some antidepressant users experience the medication as life-saving (Karp, 2006). Overall, experiences of taking antidepressant medication are significantly different and variable, in similar ways to how a diagnosis of depression is experienced in a complex range of ways.

Petersen (2017) provides a nuanced portrayal of the limitations, problems and advantages of experiences of taking antidepressants based on eight interviews with young adults between 20 and 30 years, diagnosed with depression in Denmark. None of Petersen’s interviewees consider antidepressants as a quick fix. They rather consider the medication as one element among others that they have to use for a limited period of time in the process of restoring identity and in regaining foothold at the social arena. One of the interviewees for instance reports that she experiences the medication as time-saving, insofar as antidepressants speeds up the process of recovering from depression and in this way, contribute positively to regaining a high energy level (Petersen, 2017: p.135). A central finding in Petersen’s interview study is that the young adults have a *pragmatic* approach to medication in the sense of thinking, “if they work, why not take them?” (Petersen 2017:132, my translation). In this way, the interviewees reflections and perspectives on the meaning of the medication in relation to the construction of identity is not imbued with ethical and moral implications, Petersen claims, but rather characterized by this noteworthy pragmatism.

Furthermore, Petersen borrows Zygmunt Bauman’s notion of “liquid modernity” to analyze depression as a condition where the depressed person experiences life as out of order. From this point of view, antidepressants are a remedy used to try and re-establish order in two different ways. First, there is the personal order, in which the purpose of the medication is to improve the depressed person’s mood. Secondly, Petersen analyzes the intake of medication as an internalization of a broader societal order. In this way, the intake of medication is also a way of trying to measure up to certain normative ideals in order to succeed. Petersen claims, in other words, in line with others (Ehrenberg, 2010) that the relatively high consumptions of antidepressants in Denmark also is a result of certain societal expectations that are difficult to measure up to. I will get back to Petersen’s social analysis of the conditions for the “depression-society” and to how the high numbers of antidepressant users is rendered possible by certain societal forces in chapter 6.

Experiences of antidepressants are not the main focus in my Ph.D. project. However, in article 3 I touch on the subject in relation to an analysis of the different kinds of

body work my informants do to try to (re)gain control over their bodies and to rebuild bodily certainty. More precisely, I focus on the relation between medication and alteration of bodily resonance as a part of the process of trying to recover from depression. In article 1, I furthermore deal with antidepressants in connection with one of my informant's resistance and ambivalence towards the medication. I analyze this as part of an overall reluctance to becoming a person who is living under the description of depression, and claim among other things that the negative reputation that depression (and antidepressants) have, is part of the reason for this resistance.

4.3.3 DEPRESSION, GENDER AND POWER

Epidemiological research shows that depression is more common among women than men. Some studies indicate that women are as much as twice as likely as men to experience depression (Kessler, 2003). Women are also estimated as being twice as likely as men to be prescribed medication for depression (Ussher, 2010). Some of the explanations for the gender difference in depression suggest that traditional female roles lead to stress that result in depression (Jack, 1991; Kessler, 2003). Another explanation is to be found in rumination theory that suggests that women have a natural tendency to dwell on problems (that men do not do to the same degree), which is the reason why women more often experience depression than men (Nolen-Hoeksema in Kessler, 2003). A third explanation has a biological starting point, claiming that women's higher rates are caused by sex hormones (as a result of for example menopause or the use of oral contraceptives) that make them more vulnerable to depression than men (Kessler, 2003: p.6). These high numbers and speculations about the explanatory factors involved in the gender difference are often the starting point for qualitative studies that investigate connections between gender, power, and experiences of depression. However, in contrast to epidemiological studies, qualitative inquiries investigating this field of depression tend to focus on social causes involved in gendered depression.

One of the most influential qualitative researchers on depression and gender is psychologist Dana C. Jack (1991) who is well known for her theory about "silencing the self". Based on a longitudinal study with the stories of twelve clinically depressed women, Jack explores how women's subjective experiences of depression are characterized by a sense of powerlessness, and a silencing of their true selves in intimate relationships with men. Jack argues that normative imperatives about being a good woman, wife, and mother influence how women act in intimate relationships. More specifically, Jack argues that women silence their authentic self in intimate relationships in order to be able to maintain these relationships. Yet, this silencing the self can lead women to consider their own feelings as invalid and not worthy of consideration, which in the end can rebound in depression (Jack, 1991: p.47).

Jack brings into focus the social nature of the causes of women's depression (and partly men's, but this is not her focus). She argues that different matters cause depression for women and men respectively. Simply put, women's depression is precipitated

due to conflict in intimate relationships whereas men's depressions are more often caused by failing to live up to for instance performance ideals. At the same time, Jack is very preoccupied with gender inequality. She illustrates how there is a dominance of masculine perspectives where women tend to judge their feelings and needs in light of their male partner's perspective, and this plays a crucial part in women's experiences of depression. Finally, Jack argues that women must reclaim their lost self and become attentive to their authentic inner self to unlock the bonds of their depression.

Valkonen and Hänninen (2012), on the other hand, investigate the link between masculinity and depression based on an interview study in Finland. The pivotal point in their study is the gendered sociocultural context where masculine ideals like strength, competence, and rationality dominate. They investigate how men's depression is related to these ideals and conclude that there is no single association between masculinity and depression in their findings. There is, on the other hand, a variety of ways in which their male interviewees relate to depression and masculinity. Despite these varieties, they deduce some main ways in which men's depression are related to masculinity. Firstly, depression is "seen as a consequence of both realized and unattained hegemonic masculinity" (Valkonen & Hänninen, 2012: p.160). Secondly, some of the interviewees located the cause of their depression within the sociocultural order, thereby challenging the hegemonic masculinity. And thirdly and interestingly, viewed in the light of the tendency to view masculinity as a source of problems in studies of masculinity, Valkonen and Hänninen find that some aspects of masculinity worked as a resource for the men themselves in coping with depression (Valkonen & Hänninen, 2012: pp.174–175).

Smith's (1999) autobiographical account of living with depression in the United Kingdom stands in contrast to this finding. He underlines, in contrast, how difficult it is for men to live with depression because of "dominant views of masculinity [that] tend to encourage the suppression of emotional stories by men in a variety of contexts, so many men become reluctant to both tell and listen to these kinds of stories" (Smith, 1999: p.276). Hegemonic masculine ideals make it difficult for men to tell narratives about emotional distress, and therefore also difficult to 'recover' their voices and repair the damage that illness has done" (Smith, 1999: p.277).

The relation between gender, power and experiences of depression has not been a focus of my project even though the majority of my informants are women. The reason for this is that I, from the beginning, have been interested in exploring experiences of depression, as well as diagnostic processes, from a phenomenologically inspired perspective. Thus, I have not been especially attentive to the theme of gender insofar as the kind of experiences I have studied most likely cut across gender differences. However, thinking about my empirical material with gendered lenses, I retrospectively recognize some of the points of impact that researchers interested in gender outline. Sarah, for instance, talked about gender inequalities in her household and about 'women's tendency to worry too much' and their 'eye for practical matters', pointing to normative gender differences that might play an important part in causing depression as well as in shaping experiences of it. In chapter 10, I elaborate further on what

a gendered perspective on experiences of depression and diagnostic processes could look like.

4.4. CONCLUDING REMARKS

My theoretical approach in the thesis is phenomenologically inspired in that I study experiences of depression by using insight from the anthropology of experience as well as the phenomenology of depression. The latter offers an interesting framework and useful analytical concepts to depict experiences of what we call depression. One of my central contributions to this work is to flesh out lived experiences of depression by providing evocative descriptions of how depression is experienced in the course of everyday life. By doing this, I furthermore depict intersubjective and intercorporeal experiences of depression. Another input to the phenomenology of depression is to attend to what people *do* in daily life to try to recover from depression, or, to put it differently, what they do to try to attune to the rhythm of everyday life by different kinds of body work (article 3).

Jackson (1996) emphasizes that a central contribution of anthropology to phenomenology in general is a fuller focus on historical, cultural, variable and relative aspects of our existence. This point entails that I pay special attention in the thesis to the macrosocial processes that impinge on experiences of depression and diagnostic processes. For instance, I highlight how experiences of depression are intertwined with normative desires of being a good worker, parent, partner, person, et cetera. Thus, failing to live up to normative standards, is an inherent part of depression experiences as well.

CHAPTER 5. ON DIAGNOSIS IN PEOPLE'S LIVES – A LITERATURE REVIEW

In this chapter I investigate what a diagnosis is, emphasizing the social, cultural and political character of diagnosis, and how the meaning of it has changed from a historical perspective. Afterwards, I introduce the sociology of diagnosis, which nurse and medical sociologist, Annemarie Jutel, has outlined. Then, I review research on how a diagnosis works in people's lives, including how they become influential in how we think about ourselves and other people's suffering. This is followed by a review of qualitative inquiries into people's experiences of being diagnosed with depression in particular. I end by summarizing the contribution of the thesis to existing research.

5.1. WHAT IS A DIAGNOSIS?

Originally, diagnosis was the medical profession's classification tool to evaluate patients' symptoms and the physical complaints they presented in clinical contexts. The purpose was to determine an appropriate treatment, and by doing so, to hopefully mitigate or cure unpleasant conditions (Jutel 2009: p.278, 2011: pp.20–21). Before medical knowledge was systematized and developed into standardized nomenclature, ancient Greek medicine used a narrative descriptive style “to evoke a picture of a disease” (Veith in Jutel, 2009: p.280; Rosenberg, 2002: p.238). The development of classificatory medicine was driven by an attempt to enable communication within the medical field, and to “further medicine as a science, providing a linguistic means to rein in its unintelligible and confused inconsistencies” (Fisher-Homberger in Jutel, 2009: p.280). This has led to where nowadays “one word, a simple disease name” (Veith in Jutel, 2009: p.280), a diagnosis, works as the bedrock of clinical research and medical practice. Western medicine has, in other words, gone from fluid and non-specific ideas about diseases to a “vocabulary of named disease pictures” that made diagnosis a central component of the definition and management of disease by end of the 19th century to the present day (Rosenberg, 2002: p.247).

The way psychiatric diagnoses are used in contemporary societies has changed remarkably from a historical perspective. Psychologist Svend Brinkmann argues that a diagnostic expansion has occurred in which medicine's monopoly on diagnoses and terminology has been democratized. Diagnoses have “travelled from the clinics and medical textbooks into popular culture”, Brinkmann writes, (2016: p.8), just as they have become institutional practices, serving a structuring function in institutional settings. The current multiple purposes to diagnostic classification entail that diagnosis is being used to satisfy a range of needs from the bureaucratic management of health

to health data collection and public planning, medical education, treatment and prognosis in national and global mental health policies and marketing strategies (Brinkmann, 2016; Brinkmann et al., 2014; Jutel, 2011; Jutel & Nettleton, 2011; Kleinman 1988a: p.9; Mayes & Horwitz, 2005; Rose, 2013; Rosenberg, 2002, 2006: p.130). Last, but not least, diagnosis has come to play an important part when it comes to identity matters at an individual and collective level.

Diagnosis is a set of changeable categories agreed upon by the medical profession to designate something as pathological and necessitating treatment. Diagnoses are not neutral or value-free but they come attached with a certain “culturally agreed-upon meaning for individual experience” (Rosenberg, 2002: p.240), and they influence how society conceptualizes and manages health and illness, as well as notions about the abnormal and the normal. In this way, “diagnoses do not exist ontologically”, as Jutel writes (2009: p.294), and they are “anything but natural” (Kleinman, 1988a: p.8). Yet, “once classification is established, we are inclined to think of the categories as natural” (Jutel, 2011: p.35), including how mental disorder is conceptualized through diagnostic categories (Brinkmann, 2016: p.13; Kleinman, 1988a: pp.8–9; Rosenberg, 2002: p.237). However, a historical glance at the changing understanding of a diagnostic category like depression, as illustrated in chapter 3, exemplifies the changeable nature of diagnosis and mental illnesses. This is not to dispute that there is anything common or “real” to diagnosis, as underlined previously. Depression and other diagnoses are “real” insofar as they are categories we believe in and act “individually and collectively on” (Rosenberg, 2002: p.240), just as the experiences they are meant to capture are painfully real for the sufferer. The point is rather to emphasize how diagnoses are based on powerful conceptual systems we have learned to use to order the world, which influence how we interpret and manage health and illness with respect to specific psychiatric categories and the criteria those categories establish (Kleinman, 1988a: p.8). In this way, the diagnostic systems capture what the powerful medical institutions “currently believe to be the ‘Way Things Are’” (Jutel, 2009: p.294), according to what is culturally and socially regarded as normal versus deviant at a given time, which again shapes individual experiences.

5.2. A SOCIOLOGY OF DIAGNOSIS

Owing to the influential role of diagnosis on various levels, Jutel calls for a sociology of diagnosis to give diagnosis a distinct disciplinary focus as a subdisciplinary field within medical sociology (Jutel 2009, 2011; Jutel & Nettleton, 2011; Petersen, 2015: p.17). The sociologist Phil Brown already advocated for a sociology of diagnosis in 1990, arguing that an explicit focus on diagnosis would provide significant insight into understanding health, illness and disease through an explicit diagnostic focus (Jutel, 2009: p.279). However, such a subdiscipline was not founded in Brown’s time. Therefore, almost two decades later, Jutel takes the cue from Brown and calls for a sociology of diagnosis once again.

According to Jutel (2011: p.9), the close relationship between diagnosis and medicalization is one of the reasons why a sociology of diagnosis has not been founded yet. This does not imply, that researchers have not studied diagnosis previously. The role of diagnosis has, for instance, been an implicit part of the vast literature on medicalization. The concept of medicalization refers to a situation where medical knowledge has a certain authority and is privileged over other forms of knowledge. It also denotes the processes whereby nonmedical aspects of human existence are redefined in medical terms, pointing to the social character of medical definitions (Bryant, 2011: p.36; Conrad & Schneider, 1980; Jutel, 2011: p.9; McGann & Hutson, 2011). However, the field of medicalization also deals with topics that do not require a diagnosis. An example is the medicalization of child-rearing, where parents read books by health professionals on this topic, which influence how they understand and carry out parenting (Jutel, 2011: p.9). Diagnosis also plays an important role in the process of medicalization, Jutel writes, referring to the close connection between medicalization and diagnosis. An explicit focus on diagnosis can thus also provide knowledge about the processes that medicalization initiates (Jutel, 2009: p.286). In the case of depression, sadness is not medical in nature, Jutel writes, but is transformed into a medical problem when a diagnosis is given. In this way, it is the diagnosis which “is a specific step in, and an enabling factor of, medicalization” (Jutel, 2009: p.285). Following this line of thought, diagnosis is “at the heart of medicalization processes” (Bryant, 2011: p.36).

Another central aspect of the sociology of diagnosis, is an analytical distinction between diagnosis as a social category and diagnosis as process. Jutel borrows these terms from sociologist Mildred Blaxter (1978). Diagnosis refers to “the preexisting set of categories agreed on by the medical profession to designate a specific condition it considers pathological” (Jutel, 2011: p.xiv), whereas process refers to how the label is applied.

In overall terms, a sociology of diagnosis offers a framework to explore the prominent role of diagnosis in health, illness, and disease from different perspectives (Jutel, 2009: p.294, 2011: p.5). In this way, a distinct sociology of diagnosis provides a platform for studying an array of topics ranging from diagnosis’ part in influencing illness experiences, patient-doctor interactions, patient compliance, lay-professional discord to public health, health education, and disease control from various diagnostic perspectives.

In this dissertation, I accept the invitation from Jutel and engage with depression from an explicit diagnostic perspective in articles 1 and 2. More specifically, I delve into the complex processes of learning to live under the description of depression, as well as individual struggles related to being diagnosed with depression (article 1). I furthermore explore how diagnosis shapes illness experiences, and in particular I analyze the host of cultural metaphors of depression. I suggest that these metaphors and images provide a space for inventive play in diagnostic cultures (article 2).

In the next section, I outline the themes that qualitative inquiries of experiences of being diagnosed with a psychiatric diagnosis deal with. Due to my involvement with the Diagnostic Culture project, I involve studies that have the diagnosis of ADHD and depression as the pivotal point in particular, as these two diagnoses have been central to the project.

5.3. QUALITATIVE STUDIES ON BEING DIAGNOSED IN GENERAL

One central aspect that the literature tends to agree upon is that diagnosis plays a powerful part in sense- and identity-making. A diagnosis is often described as a transformative event that shapes identity and contributes to rewriting the patient's narrative (Brinkmann, 2016; Jutel, 2009, 2011, 2016; Jutel & Nettleton, 2011; Karp, 1996; Martin, 2007; Nielsen, 2016). If the diagnosis is serious, it can even "leave an indelible mark on the life of the individual" (Jutel, 2016: p.92).

In that respect, Martin (2007) argues that a diagnosis brings about a new subject position where the event of being pronounced as manic depressive, which is Martin's empirical pivotal point, initiates a process in which the diagnosed person should learn to live under this particular diagnostic description; a description that comes with certain cultural and social meanings attached that influence how the diagnosed person understands herself and suffering¹³. In like manner, Karp argues that a depression diagnosis marks the beginning of an "illness career" that designates a process in which the individual is caught up with assessing the self, redefining the self, reinterpreting past selves, and attempting to construct a future self that works better. These phases are all part of a process that unavoidably causes "critical turning points in identity" (Karp, 1996: p.56).

Another common theme that the literature deals with is how a diagnosis offers an interpretive framework through which to understand and interpret predicament, that may help to systemize and transform diffuse illness experiences into a more comprehensible and tangible category (Brinkmann, 2016; Jutel, 2009: p.293; Karp, 1996; Nielsen, 2016). In this way, a diagnosis can also serve a role in communicating and legitimizing suffering to others by virtue of its explanatory power.

A diagnosis can also give access to the "sick role" (Parson, 1951) at both an individual and collective level, where a diagnosis can work as a "claim for exemption" from being blamed for one's inability to measure up to normative and practical expectations (Jutel, 2009: p.279; 2011: p.25). In this way, a diagnosis legitimizes suffering (Lewis,

¹³ Simultaneously, it is important to keep sight of, as Martin reminds us, the fact that a diagnosis does not encompass personhood entirely (Martin, 2007: p.132), but a diagnosis is one category, among many, to understand oneself through.

1995), or works as what the psychologist Ester Holte Kofod has termed a “legitimizing practice” (2015), that gives access to certain advantages such as sick leave or therapeutic support. A diagnosis’ admission to the sick role can be experienced as both a relief and as despairing, hinting at the ambivalence and idiosyncrasies common to experiences of diagnostic processes.

Brinkmann approaches diagnoses as “semiotic mediators”, that is, as a kind of interpretative resource of suffering, and charts and describes three different ways that psychiatric diagnoses can work in people’s lives based on empirical material concerning adults diagnosed with ADHD in Denmark. Yet, the findings are most likely representative of other diagnoses. First, he argues, that diagnoses are used to form part of the explanation for deviant behavior or feelings of not being like others when, for instance, life stories are summarized. In this way, the diagnosis mediates the diagnosed person’s understanding of his or her problematic behavior, and is used as an explanation for the problems encountered (Brinkmann, 2016: pp. 67–70).

Brinkmann draws attention to an interesting aspect of how a diagnosis can involve “entification”, borrowing a term from professor of psychology, Jaan Valsiner. Entification refers to a process where psychological phenomena, such as emotions or traits, are transformed into “a thing”, typically with alleged causal powers to affect action” (Brinkmann, 2016: p.69; see also Nielsen, 2016). Referring to this entity can be used to explain problematic behavior.

The process of entification is a common theme in my empirical material as well, and I use the concept in article 2 in connection with an analysis of how my informants invoke certain cultural metaphors of depression as a part of the process of learning to live under the description of depression. More specifically, I explore how the image of depression as a black dog is used to perceive of depression as a “harmful agent” (Brinkmann, 2016: p.69) that attacks one’s whole sense of being.

Secondly, Brinkmann (2016) argues, that diagnoses are used in “*self-affirming ways*, as a filter that transforms numerous life phenomena into symptoms that come to affirm the diagnosis” (p.64). Lastly, he argues that a diagnosis can be used as an “*excuse* for oneself and others, thereby disclaiming responsibility” (Brinkmann, 2016: pp.64,72). Lewis (1995) has, in like manner, portrayed how a diagnosis can play a part in abdicating responsibility. So has Karp when he accounts for how a diagnosis can involve a sense of being “victimized by a biochemically sick self” (Karp, 1996: p.73). The negative side of the acceptance of a diagnosis, Karp writes, is that it can be enfeebling, and give “force to others’ definition of oneself as helpless and a passive object of injury” (p.73).

In this way, the potential fruitful or detrimental ways a diagnosis can work in a person’s life have been discussed from different angles in the literature. On a more positive note, Brinkmann (2016) writes how a diagnosis can help the sufferer “regain some sense of personal agency and become able to cope with the difficulties” (p.52) (see also Karp, 1996; Lewis, 1995; and Nielsen, 2016) insofar as the diagnosis works as a

kind of direction indicator that comes attached with certain notions about how the illness experiences are to be treated. This makes the diagnosed person able to act on his or her distressing illness experiences. At other times, a diagnosis can lead to the formation of a patient identity, fixing the diagnosed person negatively into a sick role (Brinkman, 2016: p.52; Lewis, 1995; Martin, 2007).

Diagnoses have also been examined in light of the hegemony of brain-based explanations to mental illness. Martin argues, for instance, that a diagnosis can relieve people of guilt from their social failures because brain-based explanations remove personal responsibility. A person is, in other words, not to be made responsible for his or her faulty biology (Martin, 2010: p.378). Yet, “as the brain becomes a site of pharmacological intervention and enhancement”, Martin argues, the responsibility for its quality follows along with guilt over having a brain of damaged quality (see also Lewis, 1995).

Martin draws attention to how both diagnoses and brain explanations are used in plural ways. One of her informants, for instance, perceives his brain as a kind of “computer-like mechanism that operates on its own terms” (Martin, 2010: p.375). This was contrary to another informant who fiercely challenged the notion that illness experiences can be reduced to functions of the brain (Martin, 2010: p.373). In this way, Martin illustrates various ways of linking the activity of the brain to life circumstances, generating “many kinds of self-making projects” (Martin, 2013: p.379).

A final theme I will depict is about resistance and the inadequacy of diagnosis to depict illness experiences. The classic work of Goffman (1963) is sometimes used to argue that if a diagnosis is experienced as stigmatizing, it can lead to resistance against being labeled this way (Karp, 1994; Lewis, 1995). Resistance can also be motivated by a feeling that the diagnosis is insufficient to depict lived experiences.

Karp (2006) argues that the hegemony of brain-based explanations and biomedicine has led to loss and impoverishment, by quoting Luhrmann: “To say that mental illness is nothing but disease, is like saying that an opera is nothing but musical notes. It impoverishes us. It impoverishes our sense of human possibility” (p.209). In a similar way, Brinkmann argues that the hegemony of the diagnostic language is at the expense of other languages, such as religious, existential, political, and moral languages, which leads to an impoverishment and a narrowing of our self-understanding (Brinkmann, 2016: p.4). A final example is medical anthropologist, Thomas Csordas (2014), who expresses the inadequacy of diagnoses to sufficiently describe painful illness experiences the following way: “as descriptors of the existential realities of people’s lives, the nature of the affliction, and the problems they are struggling with, they [diagnoses] are invariably imprecise and two-dimensional” (p.202).

In overall terms, the critique addresses the insufficiency of the diagnostic language and a biomedical framework to adequately depict what complex and diffuse illness experiences *feel* like. This is a critique that in many ways resonates with the reasons

for Bridget's resistance which I unfold in article 1. In article 2, I argue that the inadequacy of diagnosis to depict illness experiences, along with the indescribable nature of depression, is a central reason why people use metaphors of depression to become familiarized with the diagnosis. In this way, metaphors play an important part in bridging lived experiences and diagnostic categories.

In the next section, I delve into qualitative studies that examine how adults experience being diagnosed with depression.

5.4. QUALITATIVE INQUIRIES ON BEING DIAGNOSED WITH DEPRESSION: A LITERATURE REVIEW

There are remarkably few qualitative works on depression with an explicit diagnostic perspective of depression based on analyses of first-person accounts. Thus, the articles I have chosen to include are also the most cited and qualified in the field. Besides attending to experiences of depression and diagnostic processes, these studies also examine the variety of explanatory causes of depression people use; explanations that oscillate between a spectrum of biomedical and nonmedical factors, pointing to the variety of ways that people interpret the broad category of depression in everyday life.

The American sociologist David A. Karp is one of the most influential and award-winning qualitative depression researchers. Karp has published several works on depression based on interviews with over 100 people diagnosed with depression (Karp, 1993, 1994, 1996, 2006) and their relatives (2000). Karp covers a wide range of topics in his work, such as experiences of taking antidepressants, the obstacles depression presents in daily life, including relations with family and friends, and how sufferers try to cope with depression. Yet, one of his main arguments is that depression, cut to the bone, is experienced as disconnection, isolation and withdrawal, and that depression involves a critical identity turning point (1996).

People's experiences of being diagnosed with depression and the diagnostic process per se is seldom an explicit focus in Karp's work, even though he deals with the topic now and then. Karp describes the diagnostic process as characterized by a course over which his respondents had felt something was wrong for a long time. Eventually, they contacted a doctor who diagnosed them with depression (Karp, 1996: p.39). He depicts how several of his respondents' dislike being categorized as someone with a mental disorder as the diagnosis places them in a low social category in terms of their new social identity as a depressed person, referring to the stigma associated with mental illness. He also depicts how there is a difference regarding whether the respondents, as Karp calls them, experience the diagnosis as a positive or negative event in their lives. Karp finds that the diagnosis was in particular welcomed among those of his respondents who had not been feeling well for years without being able to pinpoint the cause. The diagnosis thus provided an important social recognition of their condition along with an explanation and hope of resolution (Karp, 1996: pp.65–66). Interestingly, Karp describes how his respondents initially interpreted their problems as

caused by social circumstances. The new sick role (by virtue of the diagnosis) led to a redefinition of what was causing the suffering. Thus, a transformation process occurred from locating the problems in the social circumstances to interpreting them as caused by an internal problem, involving a new identity as a person with a biochemical disorder (Karp, 1996: p.76).

Interestingly, Karp finds that his respondents localize the reasons for depression in *either* their biography *or* their flawed biology. A couple of them interpret their depression and their specific situations as the result of a complex interplay between their personal history, life events and a chemical imbalance, thus combining biological and environmental explanations. Furthermore, it is very rare that they relate their depression to broader cultural and social tendencies (Karp, 1996: p.166, 2006: p.78).

The findings in my study differ remarkably from those of Karp at this point, as the tendency in my study is that the informants to a larger degree combine a complex of biological, personal, and environmental explanations when they account for the causes of their depression. The tendency is furthermore that they emphasize personal and social factors involved in depression, and downplay (or even refuse) biological ones, just as they combine different nonmedical and medical explanations creatively and sometimes in seemingly contradictory ways. I believe, this difference reflects a development in how depression is widely perceived, keeping the 21 years there is between Karp's study and mine in mind, as well as the different cultural contexts in which the research has been conducted. The difference could also indicate that the psychopharmacological industry's influence on public concepts of depression might be more pronounced in the USA than in Denmark, as Ilpo Helén has argued (2007: p.151). This implies that brain discourses on depression and other mental disorders might have been, and still are, more widespread in America than in Denmark. The differences can also be seen as an example of how conceptualizations of depression and other mental disorders are changeable and contingent. It could be that conceptualizations of depression have moved (and currently are moving) from being regarded as mainly brain disorders to nowadays where depression "is widely acknowledged as resulting from a complex [and indefinable] interplay of biopsychosocial forces in contemporary Western societies" (Fullugar & O'Brien, 2012: p.1063).

5.4.1. AMBIVALENCE TOWARDS DIAGNOSIS AND MULTIPLE EXPLANATORY CAUSES OF DEPRESSION

Lewis (1995) gives a nuanced account of how individuals attach meaning to a depression diagnosis in variable, multifaceted, and sometimes even contradictory ways. She analyses four different ways 48 participants in an interview study interpret being diagnosed with a depression diagnosis. First, the diagnosis is experienced as a relief and as a helpful label that validates a problem as real, hence making individuals experience the diagnosis as a liberating source of resolution that removes the personal responsibility from the diagnosed person. The second theme, Lewis identifies, is "accepting the diagnosis but implicitly questioning it", when the diagnosis is experienced

as confusing or the diagnosed person feels uncomfortable with the term depression. The third theme is “rejecting the diagnosis as inappropriate” because it “does not relate to an individual’s understanding of their own experiences” (1995: p.374). In this connection, Lewis provides examples of interviewees who oppose rationalizing their experiences through a medical discourse, finding social or circumstantial explanations of depression more suitable, in a similar way to how Bridget initially refused to perceive her problems through a biomedical and individualized framework (article 1). Finally, Lewis identifies a fourth theme about individuals wanting a diagnosis to validate their problems but the doctor denies that the person is depressed.

Lewis furthermore considers, similar to Karp, how individuals use either *individualized* explanations of depression (in line with the medical model of depression) or *social* explanations in which life circumstances and personal reasons are emphasized (similar to the old psychoanalytic understanding of depression). As in the case with Karp’s study, these findings differ from how my informants vacillate in and out of nonmedical versus medical explanations and (see also Petersen & Madsen, 2017).

Overall, Lewis’ study elucidates a discrepancy between the “predominant clinical model of depression, where depression is defined in terms of symptoms” (1995: p.370) and individuals’ complex experiences of depression, as well as the variety of meanings they attach to the category of depression. This resonates with the findings in my research in which a discrepancy between the complex everyday world of illness experiences sometimes conflicts with biomedical practice (article 1).

Based on an interview study with people diagnosed with depression in Australia, Kokanovic and colleagues investigate the participants’ ambivalent and multifaceted experiences of being diagnosed with depression. Some saw the diagnosis as a kind of epiphany (Kokanovic et al., 2013: pp.385–386) that altered their personhood in positive ways and worked as a catalyst for self-improvement. For others, receiving a diagnosis validated their experiences as “a genuine medical problem” (Kokanovic et al., 2013: p.384). Kokanovic and colleagues (2013) furthermore illustrate how the participants continuously “move inside and outside a medicalized discourse” (p.384). In this way, they also point to a dissonance between a medicalized approach to depression with the lack of focus on social context (the diagnosis as it appears in the diagnostic manuals) and the participants’ view of depression as “entrenched social and personal problems” (p.385). There are many parallels between Kokanovic’s findings and my fieldwork. Yet my work differs on a crucial point: the participants in Kokanovic’s study welcomed a depression diagnosis (2013: pp.382–383) where one of my informants fiercely resisted labelling her distress as depression (article 1).

Petersen and Madsen (2017) explore how 16 respondents in two interview studies with young adults between the ages of 19–31 in Denmark and Norway relate to, experience and ascribe meaning to their suffering, diagnosed as depression. They take the concept of “process” as a central component to analyze how several processes are involved in getting a diagnosis and suffering from depression. They argue that living

with the diagnosis of depression is a “dynamic process”, referring to how people “vacillate in and out of various perspectives of suffering and categorization to make it fit their specific life situation and prospects for the future” (Petersen & Madsen, 2017: p.19).

Petersen and Madsen also introduce the concept of “diagnostic career”, inspired by Howard Becker’s use of career in connection with an analysis of deviant behavior. Diagnostic careers refer to the complex processes involved in living with a diagnosis. These follow “different pathways and go through various phases” (Petersen & Madsen, 2017: p.26). Diagnostic careers can be moving in a slow and unsatisfying pace, they can precede “fairly smoothly enabling improved personal understanding and intersubjective communication”, and finally, they can fluctuate “between positive outcomes and negative contemplations” (Petersen & Madsen, 2017: p.26). The concept of diagnostic career is used to address the “complex nature of suffering with depression and being diagnosed with depression” (p.29), and to how “people vacillate in and out of various orientations about their diagnosis in order to make it fit their particular circumstances” (p.28). In this way, Petersen and Madsen provide a nuanced analysis of the ambiguity of living with and relating to a depression diagnosis, insofar as they emphasize how this is “by no means static or linear but rather complex and changeable” (p.25)— a finding that is very similar to my work.

Finally, Petersen and Madsen argue that suffering from depression involves several components that are interconnected. Similar to my study, the young respondents in Petersen and Madsen’s study (2017) trace the sources of their depression to multiple explanations, such as, for instance, to “the cultural climate in contemporary society— more precisely to the normative demands of realizing and idealized self”, and to unique personal themes and life strains such as “experiences of bullying or genetic disposition” (p.23). In this way, their respondents’ sources of depression were experienced as an interconnection between societal matters, difficult individual experiences, and particular life strains.

5.5. THE CONTRIBUTION OF THIS THESIS TO THE EXISTING RESEARCH

In my fieldwork, it is common that my informants experience the process of being diagnosed with depression with ambivalence and in multiple ways, in line with how qualitative research portrays the variety and ambiguity characteristic of experiences of diagnostic processes. As Jutel and Nettleton (2011) tellingly write: “There are paradoxes inherent in medical diagnosis. A diagnosis can vindicate and blame, can legitimize or stigmatize, can facilitate access to resources just as it can restrict opportunities. A diagnosis can be welcomed or eschewed” (p.797). Reactions to diagnosis are variable and people experience and use them in many different ways. In this way, my findings resemble many of the themes the literature has depicted.

Viewed in light of the complex empirical realities that people inhabit, however, I find that qualitative research on living with a diagnosis in everyday life sometimes draws overly simplistic conclusions. More specifically, I think the literature sometimes tends to line up neatly and in organized ways in which people, for instance, experience a diagnosis as *either* explanatory, legitimizing, *or* as stigmatizing. This structured way of representing experiences of diagnoses does not necessarily provide a faithful picture of the messiness characteristic of experiences of diagnostic processes in everyday life. With this background, article 1 is an attempt to nuance and qualify the discussion of individual experiences of living with a diagnosis in everyday life by following the life and words of a single person to give a nuanced portrayal of how the same person can use and experience a diagnosis in a variable, messy and changeable way. The purpose of the article is, in other words, to illustrate how diagnostic processes not are once-and-for-all-dealt-with matters but rather messy, complicated and variable processes that involve several actors and multiple relations to the diagnosis over time. I am thus adding to the literature on diagnosis by offering an in-depth description of Bridget's multifaceted and chaotic relation to her depression diagnosis. The article furthermore contributes to the diagnostic literature by engaging with the theme of resistance about which there is sparse literature.

Another contribution of the thesis to the existing research is the in-depth portrayal of the processes involved in learning to live under the description of depression. In article 2, I take cultural metaphors, images and sounds of depression as a starting point, and examine how people use these repertoires in the process of subscribing to a diagnostic understanding of suffering. In this way, a central contribution of the thesis is to zoom in on the particular processes involved in learning to live under the description of depression in everyday life.

The purpose of article 3 is to keep the diagnosis of depression in the background in favor of an examination of how illness experiences of what we call depression unfold in everyday life. As mentioned previously, a lot of other things, besides the diagnosis, were of great importance for my informants in their everyday life. Hence, the purpose of article 3 is an attempt to do justice to my informant's stories by examining some of these other aspects. More precisely, I explore bodily sensations of depression and analyze these as an out-of-tune embodiment. Besides that, I portray what my informants do in everyday life to try to recover from depression.

CHAPTER 6. CRITICAL GAZES ON DEPRESSION

Professor of sociology Allan V. Horwitz and professor of social work Jerome C. Wakefield have proclaimed that we live in an “age of depressive disorder” (2005: p.40), insofar as depression is one of the most widespread diagnoses in the Western part of the world, only just recently slipping behind anxiety (Horwitz, 2013). As mentioned previously, the WHO anticipates depression to become the second leading cause of global disability by 2020, which makes depression one of the major global health challenges of the 21st century (Wittchen et al., 2011; WHO, 2008).

In a Danish context, depression has been termed a national disease (Sørensen in Petersen, 2016: p.20), and a report from the Danish Health Authorities from 2015 outlines depression as one of the top burden of diseases in the Danish general population (Flachs et al., 2015). Studies estimate that between 3-6 per cent of the Danish population is suffering from depression today (Gerlach in Petersen, 2016: p. 19, Olsen et al., 2004, Flachs et al., 2015, Skovlund et al., 2017). Other studies estimate that one third of the Danish population believe to have suffered from depression at some point in their life (Petersen, 2016: p. 20).

Antidepressants are the most widespread method for treating depression in Denmark. From 1999 to 2013 there was an increase of approximately 200.000 new antidepressant users, which is a relatively high increase over a rather short period of time (Petersen, 2017: p. 123). However, from 2010 to 2013, consumption of antidepressants has decreased slightly and are still slowly decreasing, while referrals to psychological therapy because of depression have increased (Skovlund et al., 2017, Yttri and Videbech, 2017: p.2). Taken together, these numbers underline how central depression is to our contemporary times, and it raises the question to why so many people are haunted by depression.

In this chapter I explicitly engage with different critical gazes upon depression that depict different ideas about why so many people suffer from depression today. The research that I engage with, argue in different ways, that the prevalence and proliferation of depression must be understood through multiple determinants, such as social, cultural, economic, and political conditions. I have already dealt with some of these perspectives that outline different reasons to the outbreak of depression in the previous chapters. However, in this chapter I depict some of the most cited and qualified voices in the sociological literature. The research I have chosen to include furthermore resonates with some of my informants’ experiences of depression and diagnostic processes.

I start by describing how critics have argued that the reason for what they claim to be a diagnostic inflation is mainly to be found in a faulty diagnostic system, leading to a conflation of normal sadness and depressive disorder (Horwitz and Wakefield, 2005, 2007). Then, I engage with literature that argues a powerful pharmaceutical industry is shaping and reinforcing the concept of depression, pointing to economic forces that are vital to the current concept formation of depression (Healy, 2004, Karp, 2006; Shorter, 2013). Lastly, I describe the sociological idea that normative transformations of individuality have paved the way for depression's success (Ehrenberg, 2010; Petersen, 2016).

These perspectives have in common that they all challenge the conceptualization of depression as a natural kind, caused by a flawed biology. They do so by emphasizing the relational, cultural, societal, economic and political conditions that shape the outbreak of depression today. In my work, I share this approach to depression, insofar as I also emphasize these aspects of experiences of depression and diagnostic processes. However, my work differs from these macro-sociological perspectives, insofar as it is based on first-person accounts of life with depression that, among other things, offer in-depth portrayals of how contemporary normative ideas about individuality are both causing depression and shaping experiences of it.

6.1. THE LOSS OF SADNESS

Several voices have criticized the diagnostic manuals for disregarding contextual factors such as social, cultural, political and economic dimensions that influence the outbreak of depression, as well as experiences of depression, as mentioned in chapter 3. Two of the most well-known critics in that respect are Horwitz and Wakefield (2005, 2007. See also Frances, 2013; Healy, 2004, and Shorter, 2001, 2013). They argue that previously, cases of difficult mental states were to a greater extent characterized as normal sadness in responses to the vicissitudes of life. Yet, this “traditional, commonsense distinction has broken down in contemporary psychiatry, resulting in the conflation of depressive disorders with normal sadness” (Horwitz and Wakefield, 2005: p.41). The high rates of depression in recent decades are, in other words, mainly due to a flawed definition of depression that has become pervasive with the publication of DSM-III in 1980. Like others, Horwitz and Wakefield mark the DSM-III as a decisive event where the ancient tradition of distinguishing between intense normal sadness and depressive disorder was abandoned with the introduction of context-free criteria (see also Brinkmann, 2016; Frances, 2013; Mayes and Horwitz, 2005, Shorter, 2013). The shift has contributed to a situation where mental health professionals and laypeople now are characterizing mental states that previously were comprehended as normal sadness, as depression.

Central to Horwitz and Wakefield argument is more specifically that the current diagnostic definition of depression has led to a conflation of depressive disorder and normal sadness, which is the main reason to the high prevalence numbers of depression. Hence, the age of depressive disorder “is partly an artifact of a logical error” in the diagnostic manuals (Horwitz and Wakefield, 2005: p.50). The faulty definition has led to an excessive use of the depression diagnosis, and to an overestimating of mental disorders in general along with incorrect treatment with mainly psychotropic drugs.

Horwitz and Wakefield’s perspective resonates with medicalization theories that deal with the tendency to medicalize problems that previously were considered non-medical, as touched upon in the previous chapter. Along with the rise of people consuming antidepressants in the 1980s, and other kinds of psychotropic drugs, research followed that dealt with the medicalization of emotional states and mental agony (Bryant, 2011: p.36; Conrad and Schneider, 1980; Conrad, 2006; Conrad, 2007; Jutel, 2011: p.9). According to theories of medicalization, the high prevalence numbers of people diagnosed with depression, is a manifestation of a process where sadness increasingly has been transformed into a medical problem that accordingly requires *medical* solutions, which come in the form of treatment with antidepressants (Jutel, 2009: p.285).

Horwitz and Wakefield point to some of the broader consequences that the medicalization of sadness has. They argue that:

“when people are constantly exposed to pharmaceutical advertisements, public service messages, and news stories that conflate depression with normal sadness, and are assured that no stigma attaches to such diagnoses, they may naturally tend to monitor themselves for such symptoms, reframe their own experiences of sadness as signs of a mental disorder, and seek professional help for their problems. The result has been skyrocketing rates of treatment for depression that give the possibly mistaken impression that actual rates of depression has increased” (Horwitz and Wakefield, 2005: p.57).

Horwitz and Wakefield argue, in other words, that normal sadness has been transformed into depressive disorder, leading to a situation where we are witnessing several false positive depression diagnoses and an overconsumption of antidepressants.

It is important to underline, that Horwitz and Wakefield have an American context as their point of departure. A central difference between Denmark and America is, that the pharmaceutical industry in Denmark is subject to much more rigorous rules when it comes to marketing of medicine than in America. However, in Denmark, people are also exposed to news stories about depression and diagnostic self-tests are also available on the Internet and in women’s magazines. Hence, we are also witnessing a de-

velopment in Denmark where people are more and more prone to monitoring and understanding themselves through a diagnostic and psychiatric vocabulary, as Brinkmann (2016) also argues.

Horwitz and Wakefield claim that many people who become depressed are reacting in appropriate ways to their specific life circumstances and to the environment they inhabit. They argue that the current context-free criteria in the DSM should be replaced by a diagnostic approach to depression that considers the role of contextual factors such as break up of romantic relationships, job losses, disappointed career goals, similar to the current bereavement exclusion. They are, in other words, proponents for a reintroduction of contextual factors in the diagnostic manuals as well as a greater awareness of how distressing experiences are caused. More specifically, Horwitz and Wakefield suggest that if symptoms of depression result from contextual factors, then we have normal suffering. If the distressing experiences continue when the contextual factors change for the better, then we have a depressive disorder. Thus, if symptoms of depression disappear when changes are made in people's environment, they should not be given a depression diagnosis. In this way, Horwitz and Wakefield argue for a reintroduction of "the traditional distinction between abnormal depression "without cause" and normal depression "with cause" (2005: p.43). They also claim that most sadness diminishes with the passage of time, and they suggest that changing or accepting the situations that led to the sadness "might be as effective, or more effective, than medication or psychotherapy" in the cases of sadness that results from ordinary misery (Horwitz and Wakefield, 2005: p.58).

Horwitz and Wakefield's suggestion as to how depression ought to be conceptualized, resonate with especially my informant Bridget's comprehension of depression. In the two interviews I did with her, she emphasized how she believed her agony was caused by difficult life circumstances. This made her refuse to understand her suffering through the lenses of a depression diagnosis, insofar as she believed her distress had identifiable causes that disqualified her from a depression diagnosis. As time went by, she partly embraced a diagnostic version of her suffering, and somehow found her way as a person who is living under the description of depression, as the reader will discover in article 1.

The symptom-based approach that has dominated since DSM-III and the transformation of sadness into depressive disorder has been enormously profitable for pharmaceutical companies, Horwitz and Wakefield (2005) argue. They write that the revolution in psychiatry caused by the DSM-III also created a broader market of disorders for pharmaceutical companies' products to treat (2005: p.55). The pharmaceutical companies are, in other words, "using the criteria officially sanctioned by the psychiatric profession" to legitimate their products (Horwitz and Wakefield, 2005: p.55). The companies have furthermore become economic supporter of "the activities and research of psychiatrists and advocacy groups" (Horwitz and Wakefield, 2005: p.55). This has led to a general public awareness of mental health which has warned the

public that common symptoms of sadness, sleep problems and anxiety, might be signs of a mental disorder to be treated. Thus, besides pointing to how too broad diagnostic categories are leading to pathologization of common sadness and false positives, Horwitz and Wakefield also emphasize how the rates of depression has increased owing to the pharmaceutical industry. A perspective I engage further with in the following section.

6.2. BIG PHARMA AND THE SEROTONIN HYPOTHESIS

In 1992, the science writer and medical journalist Lynn Payer introduced the concept of “disease monger” to identify the medical-industrial complex that benefitted from the widening of the diagnostic categories and contributed to spread the idea that “the greater population is either already sick or at risk of so becoming” (Jutel, 2009: p.291-291). Payer argues that a range of agents with powerful economic forces such as the pharmaceutical industry, insurance companies, and doctors abuse diagnosis to advance their own commercial and economic interests (Payer, 1992). Since Payer’s book, there has been wide-ranging critical discussion of disease mongering and especially the pharmaceutical industry’s part in the emergence of and spread of several psychiatric diagnoses and the high consumptions of psychotropic drugs (Gøtzsche, 2013, 2015; Healy, 2004; Karp, 2006; Shorter, 2001; Whitaker, 2010)¹⁴.

In the case of depression, the antidepressant story starts in 1957 where tricyclic antidepressants were discovered by the Swiss Roland Kuhn and the American Nathan Kline (Ehrenberg, 2010: p.xiv; Healy, 2004: p.7). At this time, the pharmaceutical companies involved did not have any interest in promoting these newly discovered drugs, the psychiatrist Healy writes, mainly due to the popularity of benzodiazepine (2004: p.7-9). Yet, horror stories of the benzodiazepines in the 1980s reported by academic and lay media, created a vacuum for a “new feel-good drug” to be introduced, viz., Prozac, one of the first selective serotonin reuptake inhibitor (SSRIs) on the market (Healy, 2004: p.9).

Healy argues that before the introduction of Prozac, depression was for the few. However, after the introduction of Prozac in the late 1980s, depression has been corporatized, and now a different story is told where nearly all of us are at risk of getting depression (Healy, 2004). Peter Kramer’s bestseller “Listening to Prozac” (1994),

¹⁴ The French psychiatrist Philippe Pignarre argues for instance that the invention of antidepressants is the primary reason to the high prevalence numbers of depression, claiming that depression is pharmacologically constructed (Pignarre in Petersen, 2017: p.138).

which, amongst other things, argued that you can become better than well by taking these drugs, is also often highlighted as significant to the spread of depression.

Healy argues that official depression campaigns in the US has played a significant part in promoting depression as one of the “greatest single health burdens on mankind”, and antidepressants as the solution to this alarming situation (Healy, 2004: p.10). One of the key factors that made it reasonable for many people to consume antidepressants, Healy writes, is the myth about the serotonin deficiency, that is the belief that a “lowering of the brain neurotransmitter serotonin has been demonstrated in depression” (Healy, 2004: p.11). Healy argues that this “key myth” (Healy, 2004: p.12) has become significant in popular culture, and that it is taken for granted that “serotonin is low in depressed people” even though the abnormality of serotonin in depression never has been demonstrated (Healy, 2004: p.263). Likewise, David A. Karp writes that the mantra of chemical imbalance have been repeated so many times, that it has become a “kind of unassailable cultural fact” (Karp, 2006: p.76).

Healy claims that we are facing a situation, where psychotropic drugs are sold to people who should not have them, and “whose lives may be put at risk by them” (Healy, 2004: p.1), referring to studies that have showed that antidepressants, in the worst cases, can lead to suicide. The problem is, Healy writes, that antidepressants “simply don’t work regularly. Prozac could indeed produce a better-than-well response – but not *reliably*” (Healy, 2004: p. 265), referring to the inconsistency in how people experience the effects of antidepressants.

In Denmark, one of the most prominent critics of the pharmaceutical industry and psychopharmaceuticals is the psychiatrist and professor Peter C. Gøtzsche (2013, 2015). Besides criticizing the diagnostic manuals for having too broad categories, he also argues (often very polemically) that we are using too many psychotropic drugs in Denmark. More specifically, Gøtzsche claims that clinical research is governed by the pharmaceutical industry, and he problematizes that many psychiatrists are on the industry’s payroll, which “compromise their academic integrity and judgement” (Gøtzsche, 2015: p.155, my translation). Furthermore, Gøtzsche criticizes the industry for playing down adverse effects of several drugs, and he accuses pharmaceutical companies for cheating with placebo controlled trials, and for carrying out these trials themselves (Gøtzsche, 2015:9.166). This makes him conclude that “we cannot trust the research literature which is produced by an industry that makes billions, not only by embellishing the results and covering up harmful effects of their medicine, but also by routinely lying about them to both the drug agencies and the doctors” (Gøtzsche, 2015: p.167, my translation). Gøtzsche’s critic stands in contrast to medicine proponents such as the well-reputed psychiatrist, Poul Videbech, who specializes in depression. Videbech (2015) argues that long untreated depression can harm the brain and that one of the benefits of medication is that it helps the brain to regenerate. Gøtzsche claims in stark contrast that it is the medicine that harms the brain. In this way, Gøtzsche rebukes with “the tall story about the chemical imbalance” by claiming that

rather than treating a so-called “brain damage” (which is not proven, Gøtzsche underlines), the medicine rather harms the brain (Gøtzsche, 2015: p.177). On this background Gøtzsche argues that psychotropic medicine is doing more damage than good, and he estimates that we with advantage could reduce our use of psychotropic drugs with 98 percent in a Danish context (Gøtzsche, 2015: p.182).

It should be noted, that Gøtzsche is the most extreme critics among all Danish psychiatrists, and that he on several occasions has quarreled with well-reputed Danish psychiatrists. For instance, Poul Videbech who accuses Gøtzsche for cherry-picking, that is, using the scientific literature selectively and for harming people who suffer from depression and who take antidepressants with his radical stand points (Petersen, 2017: p.125; Videbech, 2015). Nevertheless, Gøtzsche’s critique resonates with Healy’s and other critiques of the pharmaceutical industries (Whitaker, 2010). There is, in other words, most likely some truth in some of his arguments, which ought to be examined more closely (Petersen, 2017: p. 125-126).

The heated debate about over- versus under diagnosis of mental disorders in general, causative theories and psychotropic drugs is not only taking place in closed academic circles. The story of depression as a neurobiological disorder caused by a deficit of serotonin, alongside the usefulness of drugs, does not go unquestioned in public anymore, but has been challenged since the beginning of the twenty-first century (Lawlor, 2012: p.177). In Denmark, Gøtzsche has played an important part here. For instance, when I was in the middle of my fieldwork, Gøtzsche wrote a much debated feature article in “Politiken”, a leading Danish newspaper. Here, he polemically claimed that “we would all be better off if all psychotropic drugs were removed from the market” (Gøtzsche 2014). His aim with the article was to destroy widespread myths about mental illness, for instance, that they are caused by chemical imbalances in the brain, and that psychotropic drugs do not have any detrimental side effects. The article provoked a fierce public debate, resulting in polemics over the medication’s ability to relieve depression and over the morality of prescribing antidepressants. Along similar lines, at the time of writing, several news media are reporting on the results from a new Danish research project, for instance, with a headline saying “so-called sunshine drugs [lykkepiller] do not work against depression” (Danish Broadcasting Corporation, 2017) which, again, has initiated a fierce public debate.

Some of my informants, mainly the interviewees, followed these debates and were, of course, emotionally affected by them, while others did not have the energy or interest to take notice. For those who did follow these debates, their doubts about the efficiency and the relevance of medication were increased, and this interfered with the way they understood what it is to live with depression, and how they felt about being antidepressant users. Some felt they have to defend their intake of medication to both themselves and others. Others indicated their doubts about the medication but took it

to the benefit of the doubt. Most of the informants who followed the polemics, sympathized with Poul Videbech and referred to his work and his arguments when they responded to Gøtzsche's critique.

In article 1, I deal with experiences of antidepressants and the serotonin deficiency, insofar as I depict Bridget's struggles with learning to live under the description of depression, including her use of antidepressants and her resistance to understanding her suffering as depression. In article 2, I also engage with the story about depression as caused by serotonin deficit by describing how my informants use the image of a broken brain in the process of learning to live under the description of depression.

As touched upon previously, I want to draw attention to the media coverage of depression with for instance the criticism of doctor's prescription practice and the attention to detrimental side effects of antidepressants. This negative media coverage could be one of the reasons to why the use of antidepressants has been slightly decreasing contemporary since 2010 (Skovlund et al., 2017: p5; Yttri and Videbech, 2017: p.2). The decrease might indicate that something is changing in the popular conceptualization of how depression should be treated, and maybe also in lay people's understanding of what kind of distressing experiences that should count as depression. In future research, it would be interesting to explore further how public polemics about psychiatric diagnoses and psychotropic drugs interfere with how people experience psychiatric diagnoses in general and with the depression diagnosis in particular.¹⁵

6.3. THE UNATTRACTIVENESS OF DEPRESSION IN CONTEMPORARY TIME

In this section I depict the contemporary unattractiveness of depression that stands in contrast to the fashionable status of melancholia in earlier times, as depicted in chapter 3.

Ehrenberg traces the history of the psychiatric notion of depression during the second half of the twentieth century in order to describe how notions of individuality has changed. More precisely, he reviews French and Anglo-American psychiatric litera-

¹⁵ Signe Kierkegaard Cain is a journalist who has written an autobiographical book on depression and antidepressants in 2013. At an event I attended about her book, she said that she found it very upsetting to realize that she "unwittingly have been part of an experiment", describing how she felt when she discovered the lacking verifiability of the serotonin hypothesis. The disclosure made it difficult for her to continue to subscribe to this understanding of depression, which led her to reinterpret what it means to live under the description of depression. I have other similar examples in my empirical material, in which it would be interesting to examine further in future research.

ture on depression from the 1930s to the present in order to reveal mutations of individuality (Ehrenberg, 2010: p.14). Like others, Ehrenberg also emphasizes the disputes and changes within psychiatry as well as the importance of the development of and widespread use of antidepressants as significant factors leading to the current status of depression. However, in this section I in particular focus on the formative mutations of individuality and the normative changes in lifestyles that Ehrenberg outlines, as central to depressions' "medical success" (Ehrenberg, 2010: p.3).

Ehrenberg accentuates that the 1960s with its weakening of "traditions, walls, and bounds that structured our lives" (Ehrenberg, 2010: p.7) led to a break with "the disciplinary model for behaviors, the rules of authority and observance of taboos that gave social classes as well as both sexes a specific destiny" (Ehrenberg, 2010: p.4). Disciplinary norms were replaced by customs "that invited us to undertake personal initiative by enjoining us to be ourselves" (Ehrenberg, 2010: p.4). This development led to an emancipation and to a thorough notion that we are "owners of ourselves" (Ehrenberg, 2010: p.7). Hence, no traditions or moral laws are now longer telling us "who we must be and how we need to behave", Ehrenberg writes, making us "persons without guides" with few reference points (2010: p.8). The shift from disciplinary obedience to personal decision and initiative has led to the responsibility for our lives to be placed upon ourselves. This implies, that we now are basing our actions on mental capacities and internal drives instead of "being acted *upon* by an external force" (Ehrenberg, 2010: p.8).

Ehrenberg argues that this idea has spread to encompass all aspects of our existence. These modes of regulation, as Ehrenberg terms it, are so influential that they have become "*institutions of the self*", pointing to how these normative demands have become common and taken for granted rules that are thoroughgoing and valid for all (2010: p.8). Rather than emphasizing the negative consequences of this emancipation and "new-found liberty" (Ehrenberg, 2010:p.7), such as a weakening of social bonds (Karp, 1996), and a loss of meaning (Blazer, 2005)¹⁶, as other sociologists have done, Ehrenberg is descriptive and non-judgmental in his analysis. He argues that a transformation of individuality has occurred for better or worse, where we have moved from "guilt and discipline" to "responsibility and initiative" (Ehrenberg, 2010: p.9).

Nevertheless, one of the challenges the contemporary individual is confronted with in the light of these individualistic ideals about flexibility, self-realization, motivation and initiative, is depression as a pathology of inadequacy. Depression occurs when the individual is unable to measure up to these normative demands. Hence, depression

¹⁶ The American Psychiatrist, Dan Blazer (2005), points to the social origins of depression by referring to how the loss of communities, and a general sense of hopelessness and meaninglessness, characteristic of postmodern societies, influence the outbreak of depression (Blazer 2005).

“presents itself as an *illness of responsibility* in which the dominant feeling is that of failure” (Ehrenberg, 2010: p.4). The depressed individual “is a person out of gas”, who is tired of having to become himself, and feeling the “weight of our individual sovereignty” (Ehrenberg, 2010: p.9). Put differently, depression is a pathology of inadequacy that brings together all the difficulties that prevent us from realizing social ideals. Depression is the negative definitions of current cultural values, norms and expectations concerning how we ought to behave as persons. There are, in other words, an extremely negative sound to depression seen in the light of the system of norms that defines the contemporary individual. The penumbra of meaning to depression is characterized by an unattractiveness, making depression an undesirable condition in contemporary time in contrast to earlier times positive notion of melancholia. The inactivity, passivity, negativity, stagnation and withdrawal associated with depression stand, in other words, as the exact opposite of what societally is being called for. Seen in the light of these contemporary normative demands, experiences of depression do not have anything to offer, insofar as symptoms of depression are radically different from the ideals we are encouraged to strive for. Hence, depression stands in opposition to contemporary social norms.

Whereas Ehrenberg indicates that the high numbers of depression might decrease when we have grown accustomed to the new set of norms and to the changes in the societal status of mental health problems, sociologist Anders Petersen argues on the other hand, that society nowadays is demanding more of us than previously, leading to a psychological deterioration of the conditions, we live by (Petersen 2016: p:52).

Like Ehrenberg, Petersen also takes the high numbers of people diagnosed with depression and the high numbers of consumption of antidepressants as a starting point to outline societal conditions for being a human being with a specific focus on contemporary Denmark. In this way, Petersen follows Ehrenberg by putting the spotlight on contemporary normative demands such as self-realization and the request for an active and resilient self. These normative demands are central to why so many Danes use antidepressants and to an “increasing societal void of meaning”, Petersen writes (2016: p.15, my translation). More precisely, Petersen’s argues that these demands put a significant pressure on individuals which make us vulnerable to depression. Simply put, Petersen’s central argument is that the chronic strains of the performance society is of significant importance to the proliferation of depression. People find it difficult to correspond with contemporary normative demands about resilience, flexibility, mobility and adaptability and this make us exposed to depression. Hence, one of the main sources of depression, Petersen argues, it to be found in these current conditions, and in particular in what Petersen terms the “performance society”.

In article 1, I touch on the chronic strains of the performance society, insofar as I depict Bridget’s depression as triggered by an inability to measure up to certain normative standards among other things. I also engage with Ehrenberg’s depiction of depression as the exact opposite of what societally is being called for, insofar as I

analyze the contemporary unattractiveness of depression, as a central aspect to why Bridget refuses to understand her suffering through the lenses of a depression diagnosis.

6.3.1. A DIAGNOSTIC HIERARCHY

In contrast to the current unattractiveness of depression, a few contemporary tendencies and research point to how some psychiatric diagnoses such as ADHD and manic depression are more in line with contemporary notions of individuality and normative demands about how we ought to be as persons in order to succeed.

Martin (2007) depicts how the symptom of mania in manic depression is compatible with the labor markets strong demands for energetic employees, and she analyzes this as one of several reasons to why manic depression (and not depression, for instance) is framed as a potential asset in American popular culture. In work I did on ADHD in New York City, I also found that some believed ADHD to be a potential source of success to gain profitable assets from. More precisely, a small movement led by psychiatrist Edward Hallowell claims that the symptoms of hyperactivity and inattention in ADHD can be transformed into desirable and profitable traits such as creativity, an ability to think out of the box, and a high energy level, by the right (individual) effort (Rønberg and Blæsbjerg, 2013, 2014). In Nielsen's (2016) work on adults with ADHD in Denmark, she accounts for how some of her informants' wear t-shirts with the words "ADHD" printed. Others depict their ADHD diagnosis in public by referring to it on their Facebook profile picture, and yet another has a tattoo on his knuckles saying 'ADHD'. Similarly, Singh (2011) depicts how school children in Britain welcome the ADHD diagnosis and use it as a kind of advantage in certain situations in the school yard.

I find it important to underline that the main interpretation of manic depression and ADHD is still as inhibitory and restrictive conditions. Furthermore, several of the people living under the description of these diagnoses are in opposition to this positive framing of their disorder. This means, that instead of considering their diagnoses as potential assets, the majority rather experienced them as gifts they rather would not have (Martin, 2007; Rønberg and Blæsbjerg, 2013, 2014).

Nevertheless, the point is there that there seem to a central difference between how "attractive" different diagnoses are, viewed in the light of normative ideals. In my fieldwork, I have not meet any who picture themselves as suffering from depression in public by means of for instance wearing t-shirts or tattoos, which support Ehrenberg's point on the contemporary unattractiveness of depression. A few of my informants believed that the depression was valuable in the sense that they had gotten to know themselves better. Hannah for instance reported that she believed she had gained a certain valuable self-insight because of depression, similar to how Karp (2006:

p.123) discusses depression as a teacher offering valuable skills in his research. In a similar way, Hannah, and another of my informants who I have chosen to call Sarah, made a virtue out of being open about depression and the difficulties followed from this, to for instance colleagues. However, the majority of my informants' did in overall terms not experience anything valuable or profitable from their depression. Tina even laughed when I inquired about if she found the depression positive or insightful in any way:

Me: Do you feel that there is anything good or positive about... [Tina giggles] ... about what you are going through?

Tina: *No!* Not at all!

Me: No [pauses]. Not in any way, no?

Tina: No more than... I have been forced to recognize – again and again, that I'm not the amazing woman that some people... Some people want to place me on a pedestal [ironic smile in her voice] I cannot live up to that! [...] So in that way, you can say that there is something positive to it, if you absolutely want to twist your arm around it [laughter].

It is difficult to imagine depression gaining the same kind of potential attractiveness as ADHD and manic depression occasionally are framed as possessing in popular culture. Depression does not (or at least extremely rarely) contain any seemingly attractive and profitable aspects as these other psychiatric diagnoses sometimes are depicted as having (however misleading this depiction might be). I believe the main reason for this is that both ADHD and manic depression encompass certain elements, that are more in line with normative ideals today, insofar as both diagnoses hold energetic elements that are more compatible with present notions of individuality. Hence, I suggest that the discrepancy between the illness experiences of what we call depression and contemporary notions of individuality is one of the main reasons to why the majority of my informants do not find any fashionable or desirable aspects to depression.

In article 1, I depict how one of my informants, Bridget, has difficulties relating to the diagnosis and the associations she gets from the label even though she is officially diagnosed with depression, use treatment options requiring a depression diagnosis and takes antidepressant medication. Another of my informants with a similar relation to the diagnosis as Bridget is Leila, who was 29 years old at the time of the interview. In an interview Leila tells that she got her first depression when she was 22 years old, and afterwards she reluctantly started antidepressant medication. Later in the interview she says that she has never said to anyone 'I have a depression'. She actually does not feel she has a depression despite the official diagnosis, the medication and the group therapy she attends weekly. She would never use the word depression to

describe herself, she says, because “it is such a boring and unsexy word”. She would rather call herself “passionate” or “intense” or frame it like “she has some problems and an uneven temper or something like that”, similar to how Bridget prefers the concept of being a Highly Sensitive Person, as I depict in article 1. This way of relating to a diagnosis of depression is quite peculiar and seemingly contradictory. Yet this is nevertheless how some of my informants account for how they use the diagnosis in everyday life.

I suggest that the contemporary unattractiveness of depression that Ehrenberg depicts, is central to why Bridget and Leila find it very difficult to subscribe to a diagnostic understanding of their suffering, insofar as they do not wish to identify with the unattractive connotations that goes with the depression label. Hence, they find creative, selective and sometimes even contradictory ways of living under the description of depression in everyday life, as I depict in article 1 and 2.

6.4. CONCLUDING REMARKS

In this thesis, I am inspired by researchers who depict how social, political, economic and cultural conditions influence the outbreak of depression. I am in particular informed by perspectives that depict the relation between normative transformations of individuality and the high prevalence numbers of depression. I use these perspectives continuously as a valuable framework to contextualize my informants’ experiences of depression and diagnostic processes in, just as I depict how system of norms shape experiences of depression in everyday life.

This means that I give special attention to the environments my informants inhabit and the macrosocial processes that impinge on experiences of diagnostic processes and depression in the three articles that follow this chapter. I draw on the macro sociological perspectives I have outlined in this chapter, when I argue that depression is a complex phenomenon that is experienced as a very bodily and relational condition in everyday life. I am also inspired by these perspectives, when I approach experiences of depression as intertwined with for instance failing to live up to individualistic notions about initiative, motivation and adaptability, referring to how these normative standards are an inherent part of experiences of depression.

One of my central contributions to the research I have depicted in this chapter, is to provide in-depth first person descriptions of how normative ideals that define the contemporary individual are experienced among those who live under the description of depression in everyday life. I also depict the role of these norms in both triggering depression and in influencing how depression is felt in quotidian life. Whereas the macro perspectives are concerned with broader societal tendencies and take a bird’s-

eye view, my analyses take place on a different micro level, insofar as I study experiences of depression and diagnostic processes in depth by using the insights I have gained from the ethnographic fieldwork, I have conducted.

CHAPTER 7. STRUGGLING WITH A DEPRESSION DIAGNOSIS: NEGOTIATIONS WITH DIAGNOSTIC CATEGORIES

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Struggling with a depression diagnosis: Negotiations with diagnostic categories.

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Abstract

In this article, I explore how an adult experiences and negotiates the process of being diagnosed with depression, and how she struggles to learn to live under this particular diagnostic description. It is based on two interviews with one informant, Bridget, being part of a larger ethnographic fieldwork in Denmark among adults diagnosed with depression. Psychiatric diagnoses are the most common categories used when suffering and life problems are to be understood, interpreted, and acted upon in Denmark. Bridget's story is a case in which resistance against, and ongoing negotiations and complicated struggles with, a psychiatric diagnosis stand out, as she continuously struggles to articulate an oppositional stance to the dominant diagnostic categories. The negotiations take place in a complex network where medical authorities, the workplace and the diagnostic cultures play a crucial part when the depression diagnosis is negotiated. Bridget's narrative exemplifies how a medical gaze comes to prevail, and a diagnostic language comes to dominate when one is to make sense of emotional distress. Bridget's story gives a nuanced view of diagnostic processes and adds to our understanding of persons' ongoing and changing responses to diagnostic labels over time.

Key words: depression, diagnosis, resistance, negotiations, diagnostic culture, suffering.

Introduction

“I don’t have the right to object if I’m sick with depression. Then I have the sole responsibility to change, for everything that happened before I got sick, because I have a defect [...] I don’t buy into it!” (Bridget, 45 years)

In this article I explore how an adult negotiates and experiences the process of being diagnosed with depression and how she finds her way as a person, who is living under a diagnostic description. I furthermore investigate what kind of actions, experiences, and self-understandings a diagnostic framing of suffering makes possible, and how individuals change responses to diagnostic labels over time. The point of departure is two interviews with one of my informants, Bridget¹⁷, being a part of a larger ethnographic fieldwork in Denmark among adults diagnosed with depression.¹⁸ The point of illuminating Bridget’s narrative is to unfold the many-sided and sometimes conflicting and contradictory reactions that a person can experience in a diagnostic process (Kokanovic et al., 2013). By illustrating Bridget’s on-going and complicated struggle with her relation to a depression diagnosis, I aim to describe both the complexity of the diagnostic process and the complicated course of learning to live with the diagnosis in everyday life.

The anthropologist Emily Martin argues that a new subject position is brought about when a physician diagnoses a person. You are no longer a person with difficult life problems and problematic feelings, but you have also become someone who is living under the description of a particular diagnosis (Martin, 2007). That is to say, the individual may adopt the diagnostic language and the treatment offered by medicine in the aspiration to make sense of suffering. I will investigate the process of “learning to live under the description” of a depression diagnosis in this article, inspired by Martin’s term. It varies how much someone identifies with the diagnosis, as well as the importance of the diagnosis for the self-image of the person. Sometimes, the diagnosed individuals do not find the diagnosis a relief (Martin, 2007, p. 131, Lewis, 1995, p. 374), and may consequently challenge the diagnosis in a wish to provide their own understanding of their condition. This is the case for Bridget. Through the article I portray how Bridget fiercely opposes the diagnosis in the beginning when it is experienced as pathologizing and inappropriate to how she feels. She cannot recognize herself in the diagnosis and therefore puts up a fight against the biochemical explanatory framework that is presented to her by medical authorities, as illustrated in the

¹⁷ Bridget is a pseudonym chosen for reasons of confidentiality.

¹⁸ Besides interviews with 10 informants, I have attended monthly meetings in a support group hosted by the Danish Depression Association and observed a psychotherapeutic group in the psychiatry that met once a week 20 times. I have furthermore spent a week on a summer folk high school (“sommerhøjskole”) for people with depression and participated in different events with depression on the agenda as a part of my fieldwork.

opening quote above. As time goes by she gradually experiences an increasing ambiguity, and the diagnosis gradually starts to enter her self-understanding and work as a significant component in combination with other categories outside the diagnostic domain. Bridget's narrative exemplifies how a medical gaze comes to prevail, and how a diagnostic language comes to dominate when one is to make sense of emotional distress. Her narrative demonstrates how difficult it is to stick to an interpretation of one's agony that deviates from the dominant diagnostic categories. These negotiations do not happen in a closed vacuum, in Bridget's interior alone. They take place in a complex network where medical authorities, the workplace, and the diagnostic cultures play a crucial part when the depression diagnosis is negotiated.

The dominance of psychiatric diagnoses and categories

Diagnoses are important to consider when investigating the experience of depression and other mental disorders for several reasons. First of all, diagnoses are the most dominant system of categories to understand and make sense of individual illness experiences in the Western part of the world. Brinkmann and Petersen have argued that we can speak of "diagnostic cultures" characterized by psychiatric diagnoses and categories circulating into many different domains of everyday life where they are used by many diverse actors to understand and act towards suffering (Brinkmann & Petersen, 2015; Brinkmann et al., 2014; Brinkmann, 2016). At a structural level, diagnoses play a crucial part in the bureaucratic management of health where it is a gatekeeper to allocation of different kinds of treatment e.g. allocation to special education needs in schools, medication prescriptions and talking cures, and to legitimate absence from work (Rose, 2013a; Jutel, 2011; Jutel & Nettleton, 2011; Brinkmann et al., 2014; 2016). Secondly, diagnoses are extremely powerful in determining what counts as normal and pathological distress and behavior in societies. Sociologists have investigated the social processes behind the production of DSM categories, thereby addressing the political nature of mental illness (Kokanovic et al., 2013, p. 378; Horwitz & Wakefield, 2007). Diagnoses are not just invariable categories, but require on-going interpretation by numerous actors.

Several researchers have written on diagnoses at this macro and structural level. Fewer have explored individual experiences of the process of being medically diagnosed with a psychiatric diagnosis, and how adults negotiate and describe the diagnostic and labelling process. Those who have explored first person perspectives have investigated how a diagnosis (and the illness experiences) can touch on a person's sense of identity and loss of self, give rise to biographical disruption, and narrative reconstruction (Karp, 1996, 2006). Furthermore, it has been studied how a diagnosis can work in an explanatory and self-affirming way, and take responsibility away from a person (Brinkmann, 2014a, Lewis 1995). Moreover, it has been investigated how a diagnosis can produce new questions and concerns for the future and serve as a wake-up call where it helps a person to live life in a different manner (Kokanovic et al., 2013; Nielsen, 2017; Kofod, 2015; Rønberg, 2015). However, in-depth accounts of the pro-

cess of learning to live under a diagnostic description like depression are lacking. Following the words and life of a single person, as I intend to do in this article, can unfold and highlight the many-sided and contradictory reactions a person can experience in a diagnostic process.

It is important to underline that Bridget's story is not particularly representative for my fieldwork¹⁹. Rather, Bridget is an exception, since it is uncommon to have such a critical relation to the diagnosis. Bridget appeared unusually reflective to me about the process of being diagnosed with depression. Her story is interesting to bring out as a case in which resistance against, and on-going negotiations and complicated struggles with, a psychiatric diagnosis stand out²⁰. Bridget's narrative will give a nuanced view of diagnostic processes and add to our understanding of persons' on-going and changing responses to diagnostic labels over time. It will illustrate how there are not only variations between individuals according to how they relate to a diagnosis, but also how the same person can welcome and eschew a diagnosis at the same time. Some persons, like Bridget, may arrive at a negotiated middle ground after a while that accepts certain aspects of diagnoses and rejects others, often on a pragmatic or even strategic basis. At least, this was where Bridget settled with the diagnosis the last time I saw her, but it may change again in the future.

Opposing diagnosis

Let me introduce Bridget. On my way to visit Bridget for the first time I walk the long and quiet residential street with the many small detached houses that are so typical to

¹⁹ Some of the common and shared experiences among my informants are ambivalence about how the depression diagnosis offers hope, fear, and relief at the same time. It is a relief to put a name to the suffering wherewith hope follows that the initiated treatment will ease it, but fear of the future also emerges. Despite feelings of ambivalence, the majority accepts the diagnosis and does not question medical authorities and diagnostic categories to the same degree as Bridget. They all unequivocally agree the diagnosis is rewarding when it provides access to treatment and works as a legitimating practice. Regardless of these similarities, there are differences between and contradictions in how my informants experience the diagnostic process and how they relate to the diagnosis, as several other researchers have argued can be the case in diagnostic processes (Kokanovic et al, 2013; Jutel, 2009; Lewis, 1995; Karp, 1994, 1996; Jutel & Nettleton, 2011, p. 797; Brinkmann, 2016).

²⁰ There has been written several ethnographies structured around the life history of a single subject (see e.g. Biehl, 2005; Behar, 1993 or Desjarlais, 2003). One of the benefits of following the words and life of a single person is that it can help us clarify and see the juxtaposed contexts, and interactions where social life takes place (Biehl, 2005, p. 10).

middle class Denmark. I have walked lots of similar neighborhoods in my small expedition through Denmark to interview adults recently diagnosed with depression.

Bridget is a tall lady in her mid-forties who lives with her husband and two children in a town house near Copenhagen. When I met her the first time she was on a sick leave from her job as a consultant due to stress that grew into depression. She has had what she calls “dropouts” (“udfald”) or “periods where life is difficult” earlier. She had a life crisis in her mid-twenties when she graduated and did not know what to do next and again in connection with the birth of her second child due to a previous miscarriage that made her anxious during pregnancy. During these two earlier dropouts she talked with a psychologist and went to group therapy. This time she explains that the distress was triggered by a combination of criticizable working conditions, a crisis in her marriage, and being a Highly Sensitive Person. I will elaborate on this last term later. Bridget works with innovation and processes of change in the Danish welfare system and describes her job as very development-oriented. The job is very much about cost reduction by optimizing different processes and she thinks she is met with very high expectations. She believes she has a job that many people would find stressful. She was on a short sick leave due to stress two years ago but quickly got over it due to a combination of “working with herself” and talking with her boss. As a consequence, things changed and were organized in more suitable ways. Meanwhile, she got a new boss who introduced novel changes at the workplace. Bridget describes a busy period with an excessive workload with too many work assignments that exhausted her. It finally culminated in Bridget lying awake at night full of unease, speculating about her job, and not being able to sleep. At the same time things were not going well with her husband. Bridget feared that he was going to leave her and that her life would fall apart. Later, she found out that he was having a relationship with another woman, so there was actually a reason for her discomfort and worries.

The process of being diagnosed with depression typically starts with the individual experiencing some kind of illness that often results from undesirable changes in personal or social function (Jutel, 2011, p. 64). In Bridget’s case she was not able to sleep well for months, and felt anxious. At this point Bridget felt so unwell that she found it difficult to deal with her distress without seeking some kind of support. Therefore, she decided to see her primary care physician where she presented her symptoms and told a part of her illness narrative. At first, the physician told Bridget she suffered from stress and made her go to regular consultations with a stress coach. But her condition worsened, and a depression test was taken after a while. The tests scores were high enough to transform the illness experiences into a disease via the doctor, who holds the authority to diagnose a person with depression (Jutel, 2011, p. 65). Bridget was sent to a psychiatrist as a consequence of the diagnosis.

Before Bridget consulted the psychiatrist she was aware that he would probably have a medical approach to what she herself experienced as nonmedical problems. The reason why she went to the psychiatrist was out of necessity. It is the kind of help available in the Danish healthcare system. But she was still very frustrated and surprised that the psychiatrist did not show any interest in her biography and life circumstances

in the diagnostic process when she recounts the consultation with him during the interview. She emphasizes how the psychiatrist only wanted to tick off ten questions on a questionnaire and provided an explanation where depression is a disease caused by a chemical short circuit in the brain that occurs for no specific reason²¹. He told Bridget that she suffered from recurrent depressions and that her condition would worsen in the course of time in line with the necessity of an increased dose of antidepressant medication. Bridget puts up a fight against this interpretation of her suffering, the announcement of a recurrent depression diagnosis, and not least the discouraging future forecast. She insists on the importance of her life circumstances in triggering the depression, questions if it is correct to name it depression, and thinks there are strong reasons why she has fallen sick. In her own words:

“When you [doctors] start talking about that I am equipped with a defect in my brain and I just need to take medicine and everything will be fine, I just opt out. I can’t stand it! [...]. Who wouldn’t be knocked out when you were about to lose your husband? Who wouldn’t have found my working conditions criticizable? I want to have the right to object (She hits the table with her hand) [...].

Me: So, you think they deprive you of responsibility? Is that a right way of framing it?

Bridget: I can’t really figure out what it is [...]. It has something to do with not being heard [...]. I feel it has to do with stressful life circumstances. Hey, it’s depression! When I read about it then yes, maybe, it ‘is’ depression because I’m feeling unwell and apparently I’m in such a crisis that I end where I don’t feel like being here anymore. So, I ‘am’ sick when I can get that far. But what does it take to stop it? Medication hasn’t stopped it. It can’t do it [...]. You can say that I just need to take more

²¹ This is Bridget’s depiction of the consultation with the psychiatrist who might describe it differently. To be fair, I find it important to mention that some of my informants have had positive experiences with psychiatrists where they took more time and attended to their patient’s stories, concerns, and life circumstances in the diagnostic process. I also find it important to mention that depression has polyvalent meaning in different professional settings regarding what depression is and how it is to be treated. The two therapists in the group therapy where I did fieldwork were for instance more preoccupied with social than biological explanations in their work. Still, there seem to be a widespread discrepancy between distressed persons who emphasize the social context of their distress and psychiatrist’s medical preoccupation with biological explanations, as other researchers have emphasized as well (Kokanovic et al., 2013, p. 386-387; Karp, 2006, p. 78, Davidsen & Fosgerau, 2014; Lewis, 1995).

medicine, but something in me fights that [...]. And at my job, if it is only me and I'm a depression - then I'm in lack of serotonin and I just need to take a pill, then the problem isn't difficult working conditions. It's me!"²²

Several reasons are to be found why Bridget initially refuses to understand herself as someone who is living under the description of depression. First of all, there is a discrepancy between Bridget's illness experiences, and the way she understands the term depression, and therefore she cannot recognize herself in the diagnosis. Secondly, different understandings of the causes of Bridget's distress are obviously at stake when the psychiatrist and Bridget have different opinions on how Bridget's suffering is to be understood and treated. Bridget is clearly opposed to a biochemical interpretation with the accompanying treatment and the recurrent depression diagnosis that comes along with it. She does not like the reductionist element that follows from the diagnosis as she feels that the social circumstances, experienced as the causes of her distress, are neglected in favor of a chemical explanation that places the guilt in Bridget's brain without taking into account her own concerns and life circumstances. She refuses to be described in pathological psychiatric terms because she experiences that her individual situation does not fit with the language offered by medicine. She sees herself as a "normal person with dropouts" in life when things become too difficult.

The psychiatrist might think he is doing Bridget a favor by providing her with an explanation that deprives her of responsibility by locating the problem in her brain and suggesting a quick fix with the use of pills. It is a common line of thought concerning one of the benefits of being diagnosed with depression, that the diagnosis is liberating and validating because it takes away the personal responsibility for the illness from the diagnosed person (Lewis, 1995, p. 376; Karp 1994; Brinkmann, 2014b, p. 8). But it leads in the opposite direction for Bridget: She feels that the diagnosis fixates her in a sick role, cultivates passivity, and does not lead to any fruitful consequences in terms of actions and experiences, as the psychologist Svend Brinkmann has argued can be the case in a diagnostic process (2014b, p. 8). The diagnosis seems to "reinforce the sense of powerlessness which is part of the experience of depression" (Gilbert, 1992 in Lewis, 1995, p. 377) and it gives Bridget the impression that it is out of her personal control to do anything about it.

Bridget's resistance echoes anthropologist Joseph Dumit's point on how brain explanations alone disavow the individual's responsibility for the illness and at the same time gives up autonomy in the world. Dumit argues that biological inquiry into the brain's part in depression is important, but it does not tell us anything about what triggered it in the first place. More importantly, it does not create any hope of gaining

²² I have translated all quotes from Danish.

greater control and perhaps even a chance for prevention on the patient's behalf (Dumit, 2003, p. 42-43). This seems to capture some of the reasons for Bridget's frustration and resistance.

Bridget's resistance resonates with the interview study of Kokanovic and colleagues from Australia in which they underline how the participants perceived and experienced their depressions "as entrenched personal and social problems" (2013, p. 385). Like Bridget, their participants also perceived their distress as originating outside the medical domain as a result of difficult everyday social problems and life circumstances. The difference between their participants and Bridget is that they wanted and welcomed a depression diagnosis while Bridget refused it (Kokanovic et al., 2013, p. 382-383).

The psychiatrist and Bridget disagree on which treatment path to follow too. Even though Bridget has taken a low dose of antidepressants for about nine years (she plans to quit the antidepressants in the future)²³ she emphasizes the importance of alternative therapies such as exercise, yoga, mindfulness, and meditation in contrast to the psychiatrists' preoccupation with medication alone. Furthermore, and more importantly, she wants to believe she can do something actively to live her everyday life in a different manner to avoid becoming sick again.

The role of psychiatrists is obviously important in a diagnostic process. The way they communicate with the patient, that is to say how carefully they attend to patients' stories and concerns, including how they present the diagnosis, explain the causes of depression, and pronounce the future prospects have tremendous influence on how a diagnosis is received at an individual level (Lewis, 1995, p. 380-381; Karp, 2006, p. 78). On the other hand, you could easily designate Bridget's reluctance to accept the diagnosis as "disease denial" or "poor insight". Martin emphasizes how this often is the explanation doctors give when someone disagrees with the psychiatric diagnosis

²³ It is common for persons living under the description of depression to be reluctant and ambivalent about the efficacy of antidepressant medication (Kokanovic et al., 2013, p. 387, Karp, 2006). Kokanovic and colleagues even argue that for some of the participants in their study, receiving a prescription for antidepressants were more significant than being diagnosed with depression (Kokanovic et al., 2013, p. 386). The use of antidepressant medication is the most widespread practise to treat depression (Rose, 2006). Bridget and others who are reluctant about taking the pills probably take it in absence of other kinds of help. Sometimes people's reactions and actions are contradictory. Bridget's intake of antidepressant depicts how it is possible to embrace aspects of a medicalized discourse of depression by taking the pills, at the same time as she highlights its limitations in helping her with her problems (Kokanovic et al., 2013, p. 387, Karp 2006).

one is given (Martin, 2007, p. 130). No matter how psychiatrists might interpret Bridget's reaction it should be clear that Bridget refuses the diagnosis to begin with.

Strategic acceptance and increasing ambiguity

Eight months have passed since I visited Bridget the first time. Meanwhile, we have been emailing a bit, but not much, so I am eager to find out how things are working out for her. I wonder if Bridget has come more to terms with living under the description of depression, and how she relates to the diagnosis now. We are once again sitting around a table in the bright living room with press pot coffee, water, and healthy snacks like dried apricot and the like. I notice a core ball and a yoga mat in the corner. The white walls are decorated with pictures of the two children and other nice paintings. Our conversation starts and I quickly realize that Bridget has become less reluctant towards the diagnosis than she was 8 months ago. She is not so certain anymore that the problem is her working conditions and she has her doubts whether she got sick because of the job or because of herself, so to speak. She does not oppose the diagnosis in the same intense and engaged way as the last time when she spoke with a fierce voice and sometimes hit the table with her hand to underscore how hopeless the psychiatrist was, how much she disliked the neurochemical explanation, and how criticizable her working conditions were. She talks with a lower voice today and seems quieter, more reluctant and reserved compared to the first time I visited her.

One of the societal functions of diagnoses is that they work as facilitators of legitimate absence from work at an administrative and bureaucratic level (Rose, 2013a, p. 2). In Bridget's case, the depression diagnosis has made it possible for her to be on a sick leave for five months²⁴. She recently started working gradually again some months ago. During the sick leave she has communicated with her workplace and continuously made them aware that her working conditions were unsatisfactory and stressful and played a part in her getting sick. But it was only possible to criticize the workplace to a certain degree. The management informed Bridget at a meeting that they could not change the working conditions that she experiences so stressful and chaotic. They did not dare to take responsibility for her if they were the reason she fell sick, as Bridget depicts it. She is considering applying for another job in the long term, but at the moment she does not have the strength to do so. Thus, she decided to alter course and to deliberately use the diagnosis in a strategic manner to keep her job and be able to find her foothold at work again as a part of a recovery process. This is the reason she started telling a different narrative about her medical record to the management and deliberately used the psychiatrist's biochemical understanding of her distress. In Bridget's own words:

“I took the premise the psychiatrist introduced to me:
That I'm sick and its periodic and you just need to adjust

²⁴ The diagnosis ensures that Bridget's manager will receive economic compensation from the Danish government for the salary Bridget is receiving during her absence from work.

the medication. The explanation I really don't like. But I went there and presented this version to put pressure on my boss. I said: 'I've been sick before and I might have tendencies to PTSD because I lost my father and it was a difficult situation and last summer I felt a weight on my chest and blah, blah, blah'. So I simply went there and said what everyone around me said: 'I have a recurrent depression diagnosis. So this is more than work-related stress'. And it might be that [...]. But suddenly it became an advantage where it allowed me to find my footing again [...]. So I took it more upon myself that I got sick by saying that I have a depression. It relieved them from some of the responsibility”.

The management did not acknowledge - or they could not accept - Bridget's alternative version of her situation, perhaps because it did not have any impact at an administrative level. So Bridget reworked a new narrative and merged it with a diagnostic language, which the management was familiar with. They found it convincing and accepted the diagnostic version. The result of this new story was that the management let Bridget come gradually back to her old workplace where she is getting more and more responsibility and interesting job tasks as time goes by. It is not only in the work context that the diagnosis works as an explanatory model. The diagnosis suddenly made her husband understand the seriousness of her distress because he also finds the diagnostic language convincing and legitimating. They began communicating in a better manner and decided to try to save their marriage, which is going well at the moment.

Even though Bridget uses the diagnostic version strategically, tells me in details about it, and also explains how she started questioning her own version during the sick leave, she keeps on emphasizing that she still believes her illness is due to life circumstances and being a Highly Sensitive Person. At the same time, she is not so certain anymore and she does have her doubts whether her reactions are normal or outside the spectrum of normality.

While she started doubting her own interpretation during her sick leave, she was eventually somewhat reassured of the role of her workplace in the distress when she started working again. She emphasizes that she might react stronger than her colleagues, but she still found it helpful to experience that the colleagues feel pressure in the same situations as she. They too find it difficult to get the management to listen to them. This supported Bridget's understanding of the situation. Nevertheless, she does not insist on her own interpretation in the same convincing manner as she did 8 months earlier.

The increasing ambiguity Bridget is experiencing illustrates how powerful the diagnostic categories can be and how difficult it is to stick to a version of distress that deviates from the diagnostic ones. It is difficult to avoid internalizing a diagnostic

understanding about oneself to some extent especially when you use the diagnostic categories actively in different contexts, as Bridget found it necessary to do. Something has started to gradually change in Bridget's self-understanding. She has come to see herself as someone who is different from others. She is still reluctant to understand herself as a person who suffers from depression and she struggles to stick to her own understanding. She finds it easier to recognize herself as someone who is more "vulnerable" and "sensitive" in her own words. Or to be more precise: As a Highly Sensitive Person. In the following section I will describe how Bridget started to use the concept of being a Highly Sensitive Person in combination with the depression diagnosis to make sense of her experiences.

Being a Highly Sensitive Person: Navigating categories

During the two interviews Bridget reflects upon why some people become sick and others do not. In other words, she does not believe that everyone would become sick from what she went through. She believes she got sick because she is a "Highly Sensitive Person" (HSP) who is more vulnerable than the average person and because of traumatic experiences in her life. She thinks something in her might be predisposed to becoming depressed, but believes it is because of a specific inborn 'sensitiveness' – not because of a chemical imbalance in her brain.

Bridget was introduced to the concept of HSP when she attended a talk on the topic in her labour union and immediately recognized herself in the description. It was the American psychologist Elaine Aron who introduced HSP in the 1990'ties when she wrote the bestseller "The Highly Sensitive Person: How to Thrive When the World Overwhelms You" (1998). According to Aron, HSP is a distinct personality trait that affects one out of every five people. She uses different trials with functional magnetic resonance imaging to argue that Highly Sensitive Persons have a very subtle nervous system and are more easily overwhelmed by stimuli than others. People with HSP therefore need more time to process perceptions and information. It is important to underline that those who use the category emphasize that HSP is *not* a clinical diagnosis, but a personality trait with a genetic component. They underscore that sensitivity per se is not a problem. But being a Highly Sensitive Person becomes problematic because of the way many Western societies are organized at the moment, where everyone is encouraged to be extrovert, out-going, and active (Petersen, 2011; Ehrenberg, 2010). To simplify, the problem is to be found in the way society is organized rather than in the individual. HSP followers stress the importance of developing different routines to avoid overstimulation of one's nervous system e.g. making sure to have plenty of breaks during the day (e.g. eating lunch alone at work), and to reload before entering a social setting. They believe HSP can become an advantage when a person finds the right level of stimuli in everyday life.

One can easily object that it is strange that Bridget opposes the depression diagnosis and welcomes HSP as a filter through which to understand her problems when the

point of departure for both categories is biological. Bridget is criticizing the depression diagnosis for the one-sided focus on biological components, thereby neglecting social factors: So why does she feel different about HSP? The reason seems to be found in the way HSP contains both advantages and disadvantages, whereas only difficulties follows from depression. Some people are born with a greater sensitivity, following the concept of HSP, which gives some pleasant abilities like being creative, perceptive, and empathetic (Aron, 1998), which seems to speak to Bridget. The HSP category works as a kind of haven for Bridget because it fits with her own understanding of her situation. Bridget feels that the depression diagnosis identifies her “as pathological in terms of her biology” (Lewis, 1995, p. 378). The HSP category takes away the guilt from Bridget’s biology and identifies the root of the problem in contemporary normative ideals. It is easier for Bridget to embrace the HSP category because then she is a person who just needs extra care in a flawed society. She only gets negative associations from understanding herself, as a person who is living under the description of a depression diagnosis on the other hand. I ask her if she can see any appealing skills in depression as well:

“No, I simply can’t. There’s none! Depression developed from a disease model: You are sick. Something is wrong with you. But if you are sensitive you are vulnerable. Not sick [...]. So many books have been written about how it also contains strength. There’s much more energy and music in it because it can give me some insight. It also gives an explanation to how I can be a person who functions well and then nonetheless becomes sick. How can I oscillate between these two? What the hell is wrong with me? Following the sensitivity approach, it’s easier to see that I have strengths and abilities that I’ve managed. In some contexts, I’m strong and in others I have this more vulnerable side [...]. I read this article that described it as being strong as a bridge and fragile like a sandcastle [...]. I have both parts in me and it’s just difficult to handle [...]. I need to land somewhere between these two. When I’m out on the black side I’m sick and I have depression. And I do risk getting depressed again so maybe the diagnosis is correct. I’m predisposed to be recurrently depressive if I don’t do something remarkably different [...]. So maybe there is something good in accepting the diagnosis because I had to acknowledge that a change is necessary to avoid getting ill again”.

There is clearly a discrepancy between Bridget’s illness experiences and the way she understands depression. Therefore, she cannot recognize herself in this picture because she does consider herself as a person who is engaged and shows interest in several things in life even when she is sick. Still, she can recognize herself in some

elements of the depression diagnosis now: She can get so sick that she does not feel like taking part in the world anymore, which demonstrates the severity of her illness too. It is clear that Bridget has come more to terms with the depression diagnosis and increasingly started to accept and recognize herself in light of some of the elements of the category. She now acknowledges that sometimes she is a person with depression when this dark side dominates her. Bridget thinks that she has been depressed and can become so again, and the reason is to be found in a combination of being a Highly Sensitive Person, stressful working conditions, and marital problems.

Framing Bridget's distress as either HSP or depression implies different sets of understandings, but also action possibilities. Different paths are to follow depending on whether the root of the problem is located as either depression or HSP. Bridget resents the treatment path that follows from the recurrent depression diagnosis with an increased dose of medication. She prefers HSP where the solution rather is to be found in adjusting the way everyday life is lived to be able to thrive in contemporary society. The embracement of HSP, the depression diagnosis to some extent, and the terrible illness experiences, has made Bridget consider the way she organizes her everyday life. The categories gradually start to work as catalysts to facilitate changes in her everyday life. She retrospectively believes she used to expose herself to too many activities and stimuli, following especially HSP, which played a part in her getting sick with depression. She has realized that it might be rewarding for her to accept the frightening depression diagnosis to a certain degree. She now thinks the depression diagnosis can help her to direct her attention to live her life in a different manner and to avoid becoming sick with depression again. In that way she actually starts finding the depression diagnosis helpful (albeit, in a frightening manner).

The embracement of both the depression diagnosis and HSP has made her reflect upon how she can live her life more in accordance with her "psyche", as she expresses it. She has gradually started to prioritize her everyday life differently when she for instance plans on working fewer hours in the future. She is in a process of transforming from acting and identifying herself as an ambitious and active career woman to a person who is calmer, lives a quieter everyday life, and who senses her gut feeling. The change is expressed at several levels e.g. in the kind of sport she practices. She used to do marathons "until she puked" and now she practices more soft branches of sport like yoga, cycling, and meditation.

These changes depict how the severity of a recurrent depression diagnosis combined with the terrible illness experiences can function as a wake-up call where it makes a person slowly create radical changes in everyday life (Kokanovic et al., 2013, p. 385-386). But for Bridget, these changes are to a high degree driven by fear.

Discussion and concluding remarks

The aim of illuminating Bridget's struggle with her relation to the depression diagnosis has first of all been to illustrate how individual experiences with diagnostic processes are complicated and messy affairs that stretch and develop as time goes by. The ways diagnoses are negotiated is a multifaceted and complex process that involves several actors and multiple relations to the diagnosis. It can be an on-going and never-ending process to embrace a psychiatric diagnosis and to find one's way as a person who is living under the description of depression. Not everyone accepts the diagnosis straight away (or ever), but refuses it and searches for other supplementing languages and categories to make sense of their distress. The concept of being a Highly Sensitive Person leads Bridget to reinvigorated agency and to a self-understanding and action possibilities that she finds fruitful. HSP stands in contrast to the depression diagnosis that she experiences as passive with a discouraging future forecast.

The main interpretation of Bridget's narrative is that a middle ground with the depression diagnosis is negotiated after a while, which again can change in the future. I have furthermore portrayed that her self-understanding not is determined through the depression diagnosis even though it enters her self-understanding as an important factor after a while.

The way Bridget continuously resists and negotiates the depression diagnosis illustrates how there can be selective element to what someone uses from a diagnostic category depending on how one can relate to it (Brinkmann, 2014b, p. 16). But it is important to keep in mind that these selections or negotiations take place in juxtaposed contexts where several actors play an influential part. Bridget is not negotiating the depression diagnosis on her own. The medical authorities (the psychiatrist), the workplace, her husband, contemporary normative ideals, categories outside the diagnostic domain (HSP), and in particular the powerful diagnostic categories play an influential part in these on-going negotiation processes.

Bridget's narrative has further illustrated how a person can interpret and reinterpret different discourses about depression, and how she continuously tries to balance between structural and individual factors in causing her distress. When Bridget emphasizes that her depression is caused by too high ideals, too much pressure, and work-related stress she is addressing a societal critique that is similar to that of sociologist Anders Petersen. According to Petersen, the high rates of depression are to be understood in relation to society's demands for constant development, movement and self-realization that work as a chronic stressor, which rebound in the form of depression (Petersen, 2011, 2016). Bridget is addressing the same kind of societal critique, but at an individual level at the same time as she is suffering and experiencing distress at close hand. But it is a struggle she is fighting on her own and she finds that it is not possible for her to change the current societal conditions:

“The arrow points at me because I can’t change the surroundings. I can’t change the conditions because this is the way our lives are set up. So I’m the one that needs to change the most because it’s possible for me to do that. I don’t always think it’s fair [...]. But I cannot change the conditions in everyday life. I need to realize that to survive”.

Many persons who oppose diagnostic categories like Bridget probably end up with this conclusion in their struggle. It is extremely difficult to change structural conditions and normative values at an individual level with no support from others, as the sociologist David Karp has argued several places (1994, p. 363; 1996; 2006, p. 222). It is easier to change individuals than social structures and simpler to choose the path of self-development, as Bridget did, in order to be able to function well and to avoid becoming sick with depression again²⁵.

This leads me to another more critical and supplementary interpretation, which has been a premise through this article: That Bridget has lost her struggle to some extent. The prevailing biomedical gaze and the diagnostic language won somewhat and got their logic across. Bridget’s narrative shows how extremely difficult it is to challenge dominating diagnostic and neurochemical interpretations of distress and mental disorder without support from others. Her story shows how hard it is to stick to an understanding of one’s distress that differs from the dominant diagnostic categories. In that way, Bridget’s narrative highlights more general characteristics of the society in question as well: We live in a biomedical age where the neurosciences and the diagnostic categories increasingly influence our way of understanding the kind of beings we think we are, including the way we make sense of suffering and distress, as Rose and Abi-Rached among others have argued (Rose & Abi-Rached, 2013, p.1-24; Rose, 2013b; Lock & Farquhar, 2007, p. 435-436, Brinkmann 2016). Bridget’s narrative illustrates how brain explanations have travelled into psychiatry where there is a dominance of the brain concerning what causes mental disorder and how it is to be treated (Cohn, 2012; Martin 2010; Rose 2013b). Phenomenological experiences of a person’s distress do not always count in this era because we (think that we) know that it is just about an identifiable variable, viz., the brain. This was the approach Bridget was met

²⁵ In a conversation with David Karp in April 2015 he drew my attention to the importance of people gathering in social movements. The aim of these social movements should be to challenge neurochemical interpretations of depression and other mental illnesses and medical treatment paths to make room for patients’ own stories, concerns, and interpretations of their distress. Bridget’s struggle illustrates how this also might be the path to follow in the future so that room is made for other ways of understanding various life problems and mental disorders than the dominating neurochemical, psychiatric, and diagnostic ones.

with when interacting with the psychiatrist. But brain explanations are not always useful in people's everyday life. Social, psychological, and cultural explanations and life circumstances still count tremendously when a person is to make sense of distress, as other researchers have argued and illustrated empirically as well (Kokanovic et al., 2013; Lewis 1995, Karp 1994).

This indicates that the effects of neurological account of behaviour are limited to certain aspects of life and that references to biology and the diagnostic categories do not necessarily efface all other answers given by contemporary time to the question of who we are (Rose and Abi-Rached, 2013, p. 1, 9) and how we are to understand and handle suffering. Besides Bridget's insistence on sticking to an idea where circumstances outside herself play a huge part in her getting ill, she also came across the HSP category, which she embraced and uses actively, which illustrates how several narratives and categories *do* exist to make sense of distress. At the same time, Bridget's story inevitably elucidates how there is a dominance of neurological explanations of emotional distress and a diagnostic language when a person is to make sense of emotional distress.

One direction for future research on depression and mental disorder is to look further into the broader social factors that contribute to individual experiences of emotional distress from a first person perspective. What are the individual and societal expectations about the role of sadness, disappointment, frustration, and other negative emotions that are related to the depression diagnosis, and how do people living under the description of depression (and other psychiatric diagnoses) relate to these? This however, requires further empirical investigations from a first person perspective on living under the description of different psychiatric diagnoses in different contexts.

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CHAPTER 8. LIVING UNDER A DIAGNOSTIC DESCRIPTION: NAVIGATING IMAGES, METAPHORS AND SOUNDS OF DEPRESSION

Rønberg, M.T. (2017) Living under a diagnostic description: Navigating Images, Metaphors and Sounds of Depression. *Subjectivity*, submitted.

Living Under a Diagnostic Description: Navigating Images, Metaphors and Sounds of Depression

ABSTRACT: In this article, I analyze three images of depression from fieldwork conducted in Denmark: Depression as a black dog, a jarring dark sound, and a broken brain. These images provide different stories of experiences of depression, as well as its causes and treatment. I explore how people use images, metaphors, and sounds in the process of “learning to live under the description” of depression (Martin, 2007). I argue that metaphors, images and sounds of depression play a significant part in the process of transforming clinical depression diagnoses into images that resonate with illness experiences and unique lives. In closing, I compare the three images, and discuss benefits and drawbacks of each. I suggest that cultural repertoires on depression provide a space for inventive play with a depression diagnosis, pointing to a creativity, selectivity and variability in how people relate to a diagnosis in present-day diagnostic cultures.

KEYWORDS: Depression, metaphor, inventive play, diagnosis, experience, diagnostic cultures

“I had a black dog. His name was depression. Whenever the black dog made an appearance, I felt empty and life just seemed to slow down (the main character in the video is looking into a mirror. But instead of seeing his own reflection, he is seeing a black dog). He could surprise me with a visit for no reason or occasion. The black dog made me look and feel older than my years” (World Health Organization, 2012).

These lines are an excerpt from the voiceover in a YouTube video that portrays depression as a black dog. The World Health Organization (WHO) is behind the video from 2012 that lasts about four minutes and has approximately eight million views so far. It is based on the American writer Matthew Johnstone’s (2005) short illustrated book, in which he visualizes depression as a black dog. Throughout the video, you see the black dog portrayed as a part of the male character: as his shadow on the wall, sitting in his eyes or inside his skull, and having crawled into his interior and hijacked his body. In the video the man is on the floor, on all fours, and his body is transparent through an x-ray where you can see the black dog inhabiting him. Depression is, in other words, depicted as a disorder that takes possession of the individual’s whole sense of being. Apparently, Winston Churchill was the first who made the symbolization of depression in terms of the black dog famous (Emmons, 2010, p. 104). In this manner, depression is visualized as something that happens to you, a disease, symbolized by the individual who is troubled by depression being invaded by a black dog.

Some of my informants diagnosed with depression made me aware of this video when I was conducting an ethnographic fieldwork on depression in Denmark. The black dog helps them in the process of trying to understand what depression is about. They use the image as a kind of helpful mediator that can transform the diffuse depression diagnosis into something more tangible; Into an image that evokes a response and resonate with their unique lives and illness experiences.

When reading through my empirical material, I have repeatedly been struck by how it contains creative and metaphorical descriptions of depression. It has, furthermore, been noticeable that there is no single understanding of depression. There is, instead, a multiplicity of stories, or what I call *images*, of depression, underlining the diverse ways depression unfolds in my fieldwork. Sometimes, depression is pictured as an evil entity invading one’s whole sense of being (the black dog). At other times, depression is pictured as a jarring dark sound. And from time to time, depression is portrayed by the metaphor of a chemical imbalance in a broken brain to be adjusted with medication. These picturesque descriptions can tell us something about how depression diagnoses are put to use in people’s everyday life outside the clinic where diagnoses are made. Taking my point of departure in images, metaphors, and stories of depression, I explore how people transform clinical depression diagnoses into images that resonate with their illness experiences and unique lives, by drawing on cultural repertoires that deal with depression.

It is common among my informants that they experience the process of being diagnosed with depression with ambivalence. A diagnosis can simultaneously be a relief and a terrifying event that may induce conflicting emotions of hope and fear. Some find the diagnosis fruitful, since it provides access to treatment and a useful explanation to experienced distress. For others, the diagnosis can seem alienating, and some of my informants have difficulties relating to it and recognizing themselves in the diagnostic description (see this unpacked in more detail in xxxx). There is, in other words, a complexity and range of responses among my informants to being diagnosed with depression. Regardless of how they experience the diagnostic process, it is characteristic that they all experience the diagnosis of depression as a rather diffuse and intangible clinical entity. As a consequence, they initiate an explorative and bewildering process, to varying extents, where they try to familiarize themselves with the diagnosis by consulting cultural repertoires on depression. This is a process that seeks to translate the diffuse diagnosis of depression into images, metaphors, and sounds one can identify with. I call this the process of “learning to live under the description of depression”, borrowing a term from anthropologist Emily Martin (2007).

Martin argues that a new subject position is brought about when a person is diagnosed with a psychiatric disorder. Hence, the diagnosed person has to learn to live under this particular diagnostic description. I find it important to underline that the description of depression is one out of many descriptions my informants live by. They also live under several other descriptions, which come attached with certain cultural and social meanings, for example, woman, man, husband, wife, or mother, father, just to mention a few. All these descriptions influence how they understand themselves, their lives, and their suffering (Martin, 2007, p. 10). However, the main focus here is on how a person understands oneself through different images of the depression diagnosis. I am adding *process* to Martins’ term, because I am interested in examining *how* someone becomes a person who is living under the description of depression. I am, in other words, exploring how people use metaphors, images, and stories of depression in the process of subscribing to a diagnostic understanding of suffering. The concept of process can capture the changeableness, complexity, and ambiguity that characterize “getting, living and suffering from depression” (Petersen and Madsen, 2017, p. 25). I am aware that several processes are involved in this. For the sake of clarity, I will refer to a singular process in the following, keeping the plural and ambivalent character of these processes in mind. On this background I argue, that despite the dominance of a psychiatric and diagnostic idiom, there is, nevertheless, a richness, creativity, and a variability in how people navigate within cultural repertoires on depression in the process of learning to live under the description of depression in everyday life. I suggest that metaphors, images, and sounds of depression leave a scope for individual agency, how small it may be, for several ways of interpreting experiences, diagnosed as depression.

In the following, I start by contextualizing depression in “diagnostic cultures” (Brinkmann, 2016), and by situating the article in qualitative research on depression. Then,

I elaborate on my fieldwork and my approach to studying metaphor and experience. Afterwards, I analyze three different images of depression from my fieldwork: a black dog, a jarring dark sound, and a broken brain. I end by briefly comparing the three images and discussing the benefits and drawbacks of each.

Depression in Diagnostic Cultures

On a global scale, depression and other psychiatric diagnoses are a major focus of concern with high prevalence rates worldwide (Skovlund et al., 2017, p. 1; WHO, 2008; Wittchen, 2011). Several researchers have investigated the implications that follow from psychiatric diagnoses being the most widespread way of categorizing and making sense of suffering in the Western part of the world (Brinkmann et al., 2014; Brinkmann and Petersen, 2015; Brinkmann, 2016; Frances, 2013; Horwitz and Wakefield, 2007; Jutel, 2009, 2011; Jutel and Nettleton, 2011; Rose, 2006, 2013; Shweder, 2008). Critics have argued that the numbers of people being diagnosed (or at risk of being) are so high, and the diagnostic language so widespread, that we can speak of “diagnostic cultures” (Brinkmann et al., 2014; Brinkmann and Petersen, 2015; Brinkmann, 2016). The term is used to characterize a situation where psychiatry’s diagnostic and biological-oriented categories increasingly are being used by various actors to define and make sense of human distress. One of the central concerns is that the diagnostic language has gained a certain hegemony at the expense of religious, existential, political, and moral language. This has led to an impoverishment of these other forms of language that “in many ways are needed to understand the different forms of human suffering and discomfort” (Brinkmann, 2016, p. 4) and, consequently, to a narrowing of our self-understanding. In similar lines, the impoverishment, loss, and reductionism, that follows from brain-based explanations of mental illness and biomedical discourses, have been problematized as well (Csordas, 2014; Good et al., 1992; Karp, 1996, 2006; Kleinman, 1988a; Jenkins, 2015; Martin, 2007, 2010; Rose, 2007). Nevertheless, little research has provided in-depth explorations of how a diagnosis like depression plays out in everyday life among those who are living under the description.

Those who have explored experiences of being diagnosed with a psychiatric diagnosis in general tend to agree, that a diagnosis is a transforming event that touch on a person’s sense of self and identity profoundly. A diagnosis shapes experiences of suffering by offering an interpretive framework that helps systemize diffuse illness experiences into a more comprehensible and tangible category. A diagnosis can also serve a role in communicating and legitimizing suffering to others by virtue of its explanatory power (Brinkmann, 2016; Jutel, 2009, p. 293, 2011, p. 25; Jutel and Nettleton, 2011, p. 794; Karp, 1996; Kokanovic et al., 2013; Martin, 2007; Nielsen, 2016, Trivelli, 2014). A diagnosis furthermore seeks to generalize and to encapsulate diverse human beings with different life trajectories, family histories and idiosyncrasies

(Jutel, 2011, p. 37). Thus, another theme is the inadequacy of a diagnosis to sufficiently designate the difficult experiences, the categories are supposed to capture. A diagnosis does not, in other words, always sufficiently depict what depression *feels* like (Brinkmann, 2016; Csordas, 2014; Karp, 1996, 2006; Martin, 2007, 2010, p. 369). I suggest that the diffuse and sometimes alienating character of a depression diagnosis is part of the reason to why people consult cultural repertoires on depression. However, far too little attention has been paid to the specific processes involved in subscribing to a depression diagnosis, and thus learning to live under the description of depression²⁶.

When it comes to depression and metaphors, the sparse research that has been done directly on this theme shows, how metaphors of depression (and depressions predecessor, melancholia) have been available for many centuries in the Western part of the world (Jackson, 1986; Schoeneman et al., 2004, p. 329). The metaphors of darkness and shadow for instance, cut across time periods and represent the feelings of being lost and losing one's sense of hope (Lawlor, 2012, p. 27-28).

Schoeneman and colleagues take their point of departure in the novelist William Styron's (1990) memoir on depression, and systematically analyze the metaphors for depression that are contained within. They divide the metaphors into thematic clusters, such as adversity, malevolence, and annihilation, and illustrate how depression has a directionality, such as down, in, and away (Schoeneman et al., 2004, p. 334). The downward directionality in depression, and the negative associations that come with it, is part of a larger cultural system where, in general, good is up and bad is down (Schoeneman et al., 2004, p. 340). According to Lakoff and Johnson, there is a physical foundation for talking about depression with this downward directionality, viz., that a drooping, hanging body posture is normally associated with being sad and depressed, while a straight, upright posture is associated with a positive emotional state of mind (Lakoff and Johnson, 1980, p. 24-25). This is also exemplified in the stereotypical image of the melancholic individual, often portrayed as "a figure with a dark or shadowed complexion who is in a seated position with downcast eyes and head in hand – the 'philosopher's pose'" (Schoeneman et al., 2004, p. 329).

Metaphors of depression are not the main focus in the majority of qualitative studies

²⁶ Those who have explored experiences of depression within a qualitative framework have highlighted the limitations of a biomedical approach to depression, and how people vacillate in and out of a medicalized discourse of depression (Karp, 1994, 1996; Kokanovic et al., 2013; Lewis, 1995; Petersen and Madsen, 2017). Others have examined the relations between depression, gender and power (see e.g. Emslie et al., 2006; Fullugar and O'Brien, 2012; Jack, 1991; Smith, 1999; Valkonen and Hänninen, 2013), and cross-cultural perspectives on the connections between conceptualizations of depression and culture (Alemi et al., 2016; Kleinman and Good, 1985; Kleinman, 2004; Kokanovic et al., 2008, 2010).

on depression. Yet, when you scrutinize them, it becomes clear that, in various different ways, they show how people diagnosed with depression apply metaphors to describe illness experiences. For instance, the sociologist David A. Karp continuously uses his respondents' metaphorical descriptions, such as that of incarceration or drowning, to mirror the themes of isolation, withdrawal, and disconnection in depression (1996, p. 28–34). The same applies to the work of philosopher Matthew Ratcliffe, where we also continuously find images and metaphors of depression, such as that of portraying depression as a quest or a journey one has to get through or overcome, “like sailing a boat through a stormy sea or finding one’s way through a dark forest” (2015, p. 24. See also Fullagar and O’Brien 2012).

My focus in this article is how people use images, metaphors, and sounds of depression in the process of “learning to live under the description” of depression (Martin, 2007). I argue that metaphors, images and sounds play a significant part in the process of transforming clinical depression diagnoses into images that resonate with illness experiences and unique lives. I suggest that cultural repertoires on depression provide a space for “inventive play” (Kirmayer, 1992), which enables the individual to adjust the diagnosis to his or her unique life and experiences. This points to a creativity, selectivity and variability in how people relate to a diagnosis in present-day diagnostic cultures. This is not to argue that the dominant diagnostic cultures, are not at work. It is rather to nuance and refine the discussion by drawing attention to the complex range of ways people live under the description of depression in everyday life by means of cultural repertoires on depression.

Studying Metaphors and Images of Depression

This article is based on fieldwork, in which I investigated adults' experiences of being diagnosed with depression, and the processes involved in learning to live under this diagnostic description in everyday life. The fieldwork consists of observing and participating in five meetings in a volunteer-based self-help group, hosted by a patients' association, as well as two conferences on depression in this setting. I furthermore participated on the patients' associations annual weekly summer folk high school (“sommerhøjskole”) for people suffering from depression²⁷. Besides that, I have observed ten sessions in a depression group led by two psychotherapists in a psychiatric

²⁷ Folk high schools are quite common in Denmark, as well as in the other Nordic countries. They are institutions for adult education that do not have any final exams, just as they do not grant any academic degrees. Most often, folk high schools have a focus on self-development and subjects are often related to the creative arts, for example to music, arts, design or intellectual courses such as religion, philosophy and psychology. The summer folk high school I attended, lasted a week, the title was “regain vitality”, and focused especially on sports, art and psychosocial education about depression.

forum. Here, I got permission to read the patients' journals, and I had informal conversations with the psychotherapists, as well as one interview. Finally, I observed individual conversations the psychotherapists had with three patients.

Besides that, I have interviewed eight women and two men about their experiences of depression. The interviews were structured around themes such as triggering events of depression, experiences of the diagnostic process, how depression unfolds and is experienced in everyday life, medication and other attempts to try and manage depression. Seven informants for interviews were recruited through a notice distributed through a patient's association. Yet, only one of the interviewees were actively involved in the patient association in the sense of using their services. I met the three others in the field sites. The interviews were mostly conducted in the interviewees' homes and lasted between one and three hours. All of the informants were interviewed once, except four, who were interviewed twice. Eight of the informants I interviewed were diagnosed with depression within the last two years before I met them, except two who were diagnosed 5-7 years ago. Finally, I have followed the media coverage of depression, including TV and radio programs dealing with the topic, as well as depression fora on Facebook, and attended different public event with depression on the agenda. One of the benefits of this multi-sited fieldwork (Marcus, 1998) is that it has offered me an opportunity to get an insight into how depression unfolds in different settings, and made me aware of different images, metaphors, and stories of depression.

My approach to studying metaphors is that I understand them as mediators or tools that can help to transform an abstract and diffuse concept like the depression diagnosis into a more familiar part of reality, that is, into something that resonates with lived experiences. A helpful characteristic of metaphors is, that they can help us understand, and provide us with a better sense of one thing by means of reference to another (Lakoff and Johnson, 1980, p. 15; Schoeneman et al., 2004). Overall, metaphors play a decisive part in how we understand and conceptualize experiences, others, and the world we live in. Moreover, metaphors both express and structure our perception of the world, and how we live in it (Jackson, 1983; Lakoff & Johnson, 1980; Schoeneman et al., 2004, p. 330).

Professor in transcultural psychiatry, Lawrence Kirmayer, writes that, "metaphors are tools for working with experience" (1992, p. 335), and emphasizes how illness experiences contain a rich source of metaphors, grounded in bodily experiences and "specific cultural forms of life" (Kirmayer, 2008, p. 333). In this way, metaphors work as interpretive sources in making sense of complex experiences such as depression (see also Schepher-Hughes and Lock, 1986). Kirmayer emphasizes the pluripotential of tools, and how there are always "new uses to which a metaphoric tool can be put" (1992, p. 335). Hence, metaphors allow for inventive play, which in the case of depression, enables the individual to create new meaning of the diagnosis from his or

her unique perspective. That metaphors both reshape and reflect experiences of illness, underlines the dynamic interplay between cultural sources of depression and immediate experiences.

Inspired by this dynamic approach to the relationship between experiences, diagnostic categories, and cultural metaphors, I understand illness experiences of what we call depression as both personal and unique, as well as shared with others in a given culture. This means, that it is difficult, if not impossible, to make a clear distinction between experiences of depression and the depression diagnosis, insofar as the illness experience and the categories and metaphors used to describe them, always are entangled (Brinkman, 2016; Hacking, 2007; Jenkins, 2015; Kirmayer, 1992, 2008; Kleinman, 1988a, 1988b; Lock, 2001; Schepher-Hughes and Lock, 1986). On a pragmatic note, there is also an impossible distinction to make, insofar as I met my informants after they were given a depression diagnosis, which means they were already interpreting their experiences through the lens of the depression diagnosis.

In the following, I go more thoroughly into how two of my informants, Hannah and Sarah, use the image of depression as a black dog. I will analyze the YouTube video as a meme they both use, yet in different ways, as a part of the process of learning to live under the description of depression.

Depression as an Invading Black Dog

Hannah is in her early thirties, and she used to be ambitious and career-driven, working long hours in the hectic television industry, until she became ill due to stress. This came from overworking, which later grew into depression, as she explains it. At the time of our first interview, she was on sick leave and struggling to get better. During the interview, we were talking about how it is to be diagnosed with depression. She told me that the diagnosis works as a kind of direction indicator, that is, she began to conduct internet searches on depression and read about it after receiving the diagnosis. One of the things Hannah came across in her research was the black dog video, which she explains the following way:

Some of the best, I've seen, is this video about the black dog [...] There is a storyteller who says: 'I have a dog and it's called depression'. And then you see how his life with this dog has been. He tells how it makes him lie awake at night, and how it is almost inhuman to walk the dog. That video gave me an understanding and, Yes! YES, that's what it's like! And I could show it to my partner and say, 'this is how I feel. This is what I'm struggling with! This is why I haven't done the dishes even though I've been home all day'. And he found it very fruitful, and maybe that is actually the best part about the diagnosis, that you are able to tell relatives that 'hey, I'm actually

sick!'.

The video served several purposes for Hannah. First of all, it struck a chord in her ('yes, that's what it's like'), and in this way, the video evoked an emotional response, insofar as the video was able to depict what she had found difficult to express. In this way, the black dog video offers a portrayal of the diffuse depression diagnosis, which Hannah and her partner can use to make her predicament, diagnosed as depression, more comprehensible through.

More specifically, Hannah uses the diagnosis and the image of the black dog as a way of understanding and making a distinction between what is her and what is the illness, the depression. It is the black dog, or 'the devil on her shoulder', that makes her act in ways she usually would not. It is the black dog that makes her grumble and overreact when a friend disappoints her. So, in this case, depression - portrayed as an invading black dog - provides an explanation, reduces guilt and self-reproach, and, interestingly, normalizes her behavior viewed in the light of the diagnosis. In her own words:

I use it [the diagnosis] daily to try to understand, well, is this me or is it my disorder? For example, when I have taken things very, very badly and become incredibly upset about some things that were really just small issues, it has actually been very nice to be able to say, well, this is not me. It is my disease, my diagnosis that make me react this way. Not because it has been an excuse, but because it has helped me help myself by saying it is this devil on my shoulder and it is not me. It is a devil. A black dog [...] I think it is a relief to use it as an explanation. Well, I'm not an evil person because I scolded my friend this summer [...]. It was because of the depression that I acted the way I did [...]. It gives an explanation, but it also takes away the responsibility and says that this is normal, really. It is totally normal to be like that.

As Hannah describes in the excerpt, it is the black dog that makes her think and say negative things. It is the black dog that makes her irritable and difficult to be around. Depression is not a clinical entity here, but figuratively portrayed as a black dog that inhabits Hannah's feeling, actions, and being.

One function of a diagnosis is that it represents a transformation from 'madness' to 'disease' (Brinkman, 2016; Ehrenberg, 2010; Jutel, 2009, p. 293; Karp, 1996; Nielsen, 2017; Trivelli, 2014, p. 154). Thus, Hannah's irrational behavior and feelings are rationalized and transformed into a disorder through the diagnosis and the image of the black dog. It is not Hannah that acts, but the illness. Hence, the responsibility is also transferred onto the illness diagnosed as depression. In this way, the diagnosis has an explanatory function of depriving blame and self-reproach.

The psychologist, Svend Brinkman, terms this aspect of a psychiatric diagnosis “en-tification”, referring to a process where an emotion, or some other psychological phenomenon, is transformed into a “thing” with “alleged causal power to affect action” (Brinkman, 2016, p. 69). In order to use a diagnosis to explain problematic behavior, as Hannah does, “there has to be some kind of “harmful agent” inside the diagnosed, Brinkman writes (2016, p. 69). Hannah visualizes depression through the image of the black dog, and in this way she uses the black dog to explain how there is a “something” within her that acts on her in detrimental ways. In this way, the devil on the shoulder, the black dog is the true agent and Hannah is not to blame for her behavior.

Obviously, how the viewer interprets the black dog video varies from person to person, depending on what they fixate on. 32-year-old Sarah is another of my informants who uses the image of the black dog. Sarah has suffered from a severe bout of depression and is feeling better at the time of the interview. In line with others, Sarah describes how she had a feeling of losing herself in the awful midst of depression. She felt ‘dead’, or ‘turned off’, and ‘all senses were closed down’. She ‘could not taste the coffee’, and ‘the whole world looked different’. Sarah is very afraid that she is going to suffer from depression again in the future. She has read that the risk of getting a new depression is extremely high - about 50–80%, depending on the study - and this terrifies her. In Sarah’s case, the awful illness experiences and the depression diagnosis have led to a change in her self-understanding. She used to see herself as ‘a super-woman’, who was capable of doing a lot of things. The diagnosis and the terrifying future prospects have implied that she now perceives herself as a vulnerable woman who has to live under certain restraints in order to avoid becoming sick with depression again. The depression diagnosis has, in other words, led to a change in her self-perception, including her imaginations about the future. There is a sorrow associated with this, and she misses the person she used to be. The diagnosis and the illness experiences has also led to everyday changes. She works fewer hours than before, and she has started to exercise on a regular basis. She has changed her diet and lost ten kilos. She spends more time by herself, especially in the garden, and she has slowly started to change her circle of friends.

In our conversation, she brings up the YouTube video when we are talking about her experience of the future as frightening, and how she struggles to find a way to live with this. She uses the black dog to exemplify that “sometimes, the dog takes up the most space, and at other times I take up the space and it is in the periphery”. What Sarah is referring to in the video is at the end of it, where the man is portrayed as increasing in size in comparison to the dog, while the dog becomes progressively smaller. Nevertheless, the black dog is always there. It is noticeable how Sarah, in a similar way to Hannah, makes a distinction between herself and the black dog. In the process of learning to live under the description of depression, she, furthermore, uses the image of the black dog to try to come to terms with the uncomfortable risk that the depression might return in the future.

We can understand Hannah and Sarah's uses of the black dog video as different ways of reifying and concretizing the abstract character of depression and making the diagnosis a more familiar part of everyday life. Watching the black dog video and relating their illness experiences to the way depression is portrayed in the video is an example of how both Hannah and Sarah try to get acquainted with the depression diagnosis. It is furthermore a process; in which they gradually start to filter illness experiences through a diagnostic vocabulary by use of the image of the black dog.

Bearing in mind, that the WHO is behind the video, a logical move would be to analyze the black dog video as a kind of institutionalized metaphor, through which the WHO promotes a certain story about depression as a biological disorder to be treated with biological remedies. There is no doubt that the black dog video resembles a certain biomedical and diagnostic understanding of depression, which has become victorious since the 1980'ties (Horwitz and Wakefield, 2007; Jutel, 2011; Mayes and Horwitz, 2005, Rosenberg, 2006, p. 124)²⁸. This hegemonic narrative of depression, is communicated to laypeople through the video, which informs how people come to live under the description of depression. Nevertheless, people understand the black dog video, and thereby also depression, in various ways, as I have demonstrated by describing how Hannah and Sarah pay attention to and use different elements in the video, depending on their idiosyncratic fears, longings, aspirations and what they are struggling with in their lives. In this way, the image of the black dog allows for some kind of inventive play, enabling the individual to adjust the diagnosis to his or her unique situation and experiences.

In the following section, I will engage with the indescribable character of depression and examine an attempt to make a soundtrack out of depression.

A Sound Image of Darkness

Depression is often said to be an unimaginable condition with such an unfathomable pain that the sufferer is unable to describe it (Jamison, 1997, p. 174; Karp, 1996; Ratcliffe, 2015, p. 1-2; Styron, 1990; Trivelli, 2014). This also makes it difficult for others, who have not experienced depression, to understand. Despite the indescribable character, I have encountered several evocative and metaphoric descriptions when I asked my informants to try and describe what depression feels like. For instance, Hannah, who described it the following way: "I really felt as if I was sitting inside a bubble and screaming, and it didn't really fit into anywhere, you know, diagnosis-wise". Or

²⁸ In the context of the patients' association where I did fieldwork, depression was often described in similar ways to the black dog metaphor. For instance, when listening to talks about depression in this forum, it was often said that "depression can affect us all", depression is something a person "gets hit by", and sufferers from depression were called "depression affected" ("depressionsramte").

Tina, who thinks the word “spiritual murder” (“sjælemord”) is very illustrative to how she feels, referring to a book she has read by a psychotherapist. Or Peter, who uses the metaphor of being hit by a train to describe how he felt when the depression was at its worst: “It [the locomotive] has pulled a set of locomotives. A lot of momentum build up. And then suddenly, you stop and then all the goods wagon come and bang!”. Bridget, on the other hand, refers to the work of art by the Norwegian artist Edvard Munch, ‘The Scream’, because she thinks it captures how she “is completely broken”.

During the fieldwork, I also stumbled upon a radio program about depression, that likewise dealt with the inexpressible nature of depression. The program, from January 2017 on the radio channel P1, operated by the national Danish Broadcasting Corporation (DR), is called ‘Troubled by darkness’. On it, the radio producer, Anne, sets out to take the listener on a “harmless journey into the darkness that the vast majority contains deep down” (Danish Broadcasting Corporation, 2017). I wish it was possible to install an audio file in this article so the reader could hear the sound of depression from the program. However, in the absence of this possibility, I will try to describe the sound of darkness with words, in the following, with the limitations of this approach in mind.

Each of the six programs start with dark tones that intensify quickly in volume, before a short break, followed by a breathless gasp and a soft female voice that says “welcome in the darkness”. Then, again, intensifying tones reach a cutting culmination point, then smooth out to a scratchy and jarring background sound, before the voice speaks again, introducing the theme of the radio program.

In a similar way as the informants I have interviewed, Anne expresses the difficulty of grasping and articulating depression. I understand Anne’s purpose in engaging with the sound designer as an attempt to mediate and make depression more understandable for both herself and others. She reflects on how “sound might be the strongest means of communication we have available,” and how sound could be a better tool to communicate depression than her many failed attempts to describe it with words.

The procedure for the collaboration with the sound designer is that she, who has suffered from severe depressions, tries to describe, with words, how it feels to be in the darkness. Afterwards, the sound designer tries to convert her words into sound images, and his sound production is used in the program. Before the meeting, Anne prepared words she thought adequately describe how it feels to be in the darkness. Her descriptions do not contain any colors because “it is coal-black”, similar to my informants’ descriptions of depression. Yet Anne has managed to write down some sounds, for instance the jarring sound that goes along with a stressed feeling.

The first word on Anne’s list is “emptiness”. An empty room has a very big tone, so the sound designer produces a pending, profound, jarring, scary noise that poured out from my headphones in the reading room in which I listened to the program. Anne

says that there is loneliness in the sound and that she gets goosebumps. I get that as well from listening to the moving radio program with the gloomy minor tones, which leaves me in a certain emotional mood.

The purpose of bringing this description of the sound of darkness is to demonstrate how a medium such as sound can play a part in trying to capture difficult illness experiences like that of depression. In order to subscribe to a depression diagnosis, it is necessary to be able to see yourself in the diagnostic description, hence the importance of finding descriptions, images, metaphors - or in this case sounds - that somehow resonate with illness experiences and one's particular life situation. When the sound designer hits the right tunes, you can tell that it touches a chord in Anne. She is moved by the sound, probably because it resonates with experiences of depression that are so difficult to grasp. At least, this is what the sound of depression seemed to do for Anne. It also provides me, as an outsider, with a better sense of depression, which I can tell from my getting goosebumps on my arms from listening to the program.

In the next section, I will explore how the image of depression as a broken brain unfolds in my fieldwork, and how my informants relate to and use this image in the process of learning to live under the description of depression.

A Broken Brain Image of Depression

Me: How do you understand depression, if you were to explain what it is for you?

Leila: I'm very technical here; it is because I have something up in my brain where the serotonin level just isn't right. I have always seen it in a very technical light. I know it [depression] has come because I have been through a lot of terrible things. But I also think of it like a chemical reaction, that there is an imbalance.

A metaphoric reference to chemical imbalance as the proximate cause of mental illness, has been invoked the last three decades, as Jenkins writes, to almost all psychiatric diagnosis (2015, p. 36-37). Depression is no exception. The brain is often portrayed as somehow lying behind depression, despite the absence of a biological test or the like to confirm the assumption (Cohn, 2012; Dumit, 2003; Fuchs, 2012; Healy, 2004; Karp, 2006; Rose, 2013). We can understand the metaphor of depression as a chemical imbalance as an embodiment of a hegemonic biochemical framework, which came into existence in the 1970s, in line with the occurrence of a diagnostic and biological turn in psychiatry (Jenkins, 2015, p.36-37). It culminated with the publication of DSM-III in 1980, wherein an etiological and holistic approach to mental disorders, inspired by mainly psychoanalytic theory, was left in favor of an approach, in which clusters of symptoms was thought as constituting underlying biological disorders. This paradigmatic shift went in line with an escalation in the use of antidepressants

(Brinkmann, 2016, p. 11; Horwitz, 2002; Horwitz and Wakefield, 2007, Mayes and Horwitz, 2005).

The logic behind this metaphor of depression is quite simple. Something is wrong with the brain. There is a chemical imbalance, and it has to be adjusted with medication. I have met this image of depression several times in my fieldwork. Leila thinks she has a brain that “works differently than others”, and experiences medication as helpful because it makes it “less painful to live”. Patient associations working with depression describe it as a “brain disorder” in some of their booklets. In the radio program, the brain is portrayed “as your worst enemy in depression,” where the brain is “burning together like a hydrogen plate”. Likewise, the majority of my informants take antidepressant medication, thereby recognizing depression as, at least partly, caused by an imbalance in the brain.

Yet, contrary to how the role of the brain is taken for granted in Martins (2007, 2010) work on bipolar disorder in America, and Brinkmann (2016) and Nielsen’s (2017) work on ADHD in Denmark, the role of the brain in my fieldwork, is sometimes contested and always combined with other non-biological explanations. None of my informant’s state that depression is solely caused by a dysfunction in their brain. In my informants’ narratives about the triggers of depression, depression is portrayed as a medley of something to do with genetic determinants, heritability, a certain natural sensitivity, chemical imbalances combined with difficult life circumstances, and traumatic experiences. Leila is one of my informants who has the most ‘technical’ understanding of depression. Yet she, like the rest of my informants, perceives her brain as embedded in wider circumstances and experiences in her life. The complexity (and uncertainty) about the causes of depression are, in other words, apparent. A few of my informants even go as far as to refuse brain-based explanations, finding that the complex experiences of depression cannot be reduced to one of the brain alone. This hints at how the mantra of depression as a chemical imbalance has been challenged since the beginning of the twenty-first century (Karp, 2006, p. 76; Lawlor, 2012, p. 177). A development in which it would be interesting to explore further.

The benefit of the broken brain image is that it tells a quite simple story of depression, and outlines action possibilities that are rather easy for others to comprehend as well: Medication is (part of) the solution. As mentioned earlier, it can be extremely difficult for others to understand the experience of the profound pain of depression. However, when illness experiences are transformed into an image of a broken brain to be adjusted with medication, it provides a story of depression that some of my informant’s report that their partners and close family members are fond of. Some reported that their partners supported and encouraged their starting to take medication, even though they were reluctant about it themselves.

The partners probably liked this image of depression because of its pleasant, simple rationalization, and the hope of curability that comes with it. As Elena Trivelli artic-

ulates it, medicine - and thereby also the broken brain image - facilitate “the communication of the non-communicable by turning distress into ‘illness’, thereby making it accessible for communication and therapeutic action” (Trivelli, 2014, p. 160). In like manner, Jenkins argues, citing Malinowski, that this “master clinical trope” defines and organizes, “a complex and unwieldy bit of reality into a simple and handy form” (Jenkins 2015:38). The “imprecision and openness to polyvalent interpretations”, is exactly what gives this metaphors depression a broad appeal to various persons, “as a symbolic interpretation of what the problem could be” (Jenkins 2015:39). The broken brain image of depression can, in other words, be a simple and helpful mediator, transforming diffuse illness experiences and a depression diagnosis into an image that both oneself and important others are able to relate to.

Thus, the broken brain metaphor of depression is also used in inventive ways. It is used to provide a useful and easy-to-understand explanation that can be beneficial for both oneself and others in the process of learning to live under the description of depression. For others, this story of depression is too simple, and “empty on existential grounds” (Jenkins 2015:40), due to its reduction of the complexity inherent in the nature of depression (see this unpacked in more detail in xxxx). Furthermore, doubts about the accuracy of this story of depression can make it difficult to subscribe to. Thus, the broken brain image of depression can sometimes initiate doubt and uncertainty, as well as moral reflections about the rightness of taking medication (see e.g. Karp, 2006; Trivelli, 2014). Consequently, it can initiate a new search for novel metaphors, images, and stories of depression, in the process of learning to live under the description of depression and make the diagnosis fit lived illness experiences and unique life circumstances.

Concluding Remarks

In this article, I have examined some of the cultural repertoires regarding depression that my informants draw on as a part of the process of learning to live under the description of depression. I have argued that images, metaphors, stories, and sounds of depression work as helpful mediators in this process. By using these images as points of departure, I have demonstrated how a metaphor of depression must speak to the diagnosed person and somehow resonate with their illness experiences and unique life stories in order to subscribe to it.

My fieldwork shows that people are reflective agents in their engagement with a depression diagnosis. They pick up on different elements from cultural repertoires of depression and transform them into something they can relate to, depending on their illness experiences and personal preferences. Certain forms of media, such as videos, sound, and art, can play an important part in this process, insofar as these media can help transform the diffuse diagnosis and illness experiences into something more comprehensible and tangible.

The different images of depression I have portrayed - depression as a black dog, a jarring dark sound, and a broken brain - provide different stories of how depression is experienced, what depression is, its causes, and how it is to be treated. The black dog video visualizes depression as a condition where the sense of “being comfortably immersed in the world” (Ratcliffe, 2015, p. 15) is eliminated because of the invasion of a detrimental agent. By virtue of its communicative power, this image has an ability to create resonance with illness experiences in different ways, as I have illustrated by emphasizing how Hannah and Sarah notice different elements in the video. The broken brain image provides a quite simple story about depression, in which it is situated within a biomedical model. According to this model, depression is to be chemically addressed by means of what can seem to be an easy-to-understand solution, i.e., medication. This image of depression has a powerful intersubjective function in communication with others, by virtue of its simple portrayal of depression. In contrast to this metaphor, the sound image of darkness encompasses the complexity of experiences of depression. The benefit of this image is that it mediates illness experiences of depression by giving a *sense* of what depression feels like, at the same time as insisting on the complex and non-communicable nature of depression. In this way, the sound image of darkness contains a greater depth of complexity compared to the broken brain image that some people experience as too simple and reductionist.

My informants draw on these cultural repertoires of depression in the process of subscribing to a diagnostic understanding of experienced suffering and, in this way, interpretations of depression diagnoses are exercised within a socially and culturally constituted frame of reference. However, images, metaphors, and sounds of depression are not static, but variable, in the same way that people’s understanding of depression is changeable. It is a matter actively determined by people trying to place behavior, words, disturbing illness experiences, and what can be an alienating diagnosis “in a field of meanings” (Martin, 2007, p. 10). Similar to ethnographic studies of how the concept of depression takes culturally distinct forms in different societies (Kleinman and Good, 1985) - depression is, for instance, evocatively termed as “a cold of the soul” in Japan (Kitanaka, 2015, p. 253) - depression is, likewise, transformed into different images, metaphors, and sounds in my informants’ lives, depending on their specific situation. My informants vacillate in and out of different images, metaphors, and stories of depression, and they use several images simultaneously and sometimes in seemingly contradictory ways. In this way, the metaphors and images are by no means meant to be understood as competing or mutually exclusive, nor as capable of giving a complete picture of how depression unfolds in the lives of people living under the description. On the contrary, the descriptions of the images are, with their different degrees of complexity, meant to provide glimpses into the processes involved in learning to live under the description of depression.

On this basis, I claim that, despite the contemporary dominance of a psychiatric and diagnostic idiom in diagnostic cultures, there is, nevertheless, a richness, creativity and a variability in how people navigate within cultural repertoires of depression in

the process of learning to live under the description of depression. I argue that metaphors, images, and sounds of depression leave a scope for individual agency by providing a space for inventive play that allows the individual to adjust the diagnosis to his or her unique life trajectories, family histories and idiosyncrasies. In future research, this calls for further considerations of the role of specific cultural repertoires involved in the processes of learning to live under particular diagnostic descriptions in different cultural contexts.

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CHAPTER 9. DEPRESSION: OUT-OF-TUNE EMBODIMENT, LOSS OF BODILY RESONANCE AND BODY WORK

Rønberg, M.T. (2017) Depression: Out-of-Tune Embodiment, Loss of Bodily Resonance, and Body Work. *Medical Anthropology*, under review.

ABSTRACT

Based on fieldwork among adults suffering from depression in Denmark, I explore depression as an out-of-tune embodiment, characterized by disturbances of bodily experiences and loss of bodily resonance. I depict my informants' efforts to attune to the rhythm of everyday life through different kinds of body work. These processes are characterized by altered ways of being in the world, which are manifested in new subtle ways of living everyday life. This perspective calls for an acknowledgement of the resonant body, and provides a non-reductionist portrayal of depression that differs from the dominant understanding of depression, as an individual (brain) disorder.

KEYWORDS: Denmark, depression; body work; out-of-tune embodiment; resonance; suffering.

It feels like a big, big knot in the stomach. And then it feels like you lose the entire footing, literally speaking. You cannot feel your feet on the ground anymore. And then, a lump in the throat. And just... So all this about feeling yourself *within*. You cannot feel anything at all. Just dead. Deep emptiness. And sadness. And I felt heavy. As if all life had just gone out of me. Everything was just hard. Felt sort of betrayed. Almost. By myself. So, that is how it feels. (Sarah, 32 years)

Sarah is suffering from a condition diagnosed as severe depression. In her account of what it feels like, I find it striking how depression is portrayed as a state of disoriented being, which is felt in particular through specific bodily sensations: a knot in the stomach, a lump in the throat. Sarah describes her being in the world as permeated by thorough and staggering background feelings of heaviness and weariness in her body, where it literally feels as if she has lost her footing, and as if life is slowly disappearing out of her.

When reading through my empirical material, based on fieldwork conducted in Denmark among adults diagnosed with depression, I have repeatedly been struck by how it is packed with portrayals of bodily sensations, similar to Sarah's depiction. Using these vivid illustrations as a starting point, I approach depression as a phenomenon that involves an altered embodiment, in which one's basic orientation in the world is changed, leading to a loss of attunement and an estranged engagement with the world. In response to this detuned way of being in the world, my informants initiate different efforts to try to manage depression and attune to the rhythm of the everyday through different kinds of body work.

In Western psychiatry, and in the leading diagnostic manuals, DSM-5 and ICD-10, mental disorders, including depression, are primarily understood as an "'inner', psychological, or neurobiological disorder" (Fuchs 2013:222), "which only secondarily affects the bodily and social space" (Fuchs 2013:221). This line of thought does not only apply to depression. Several researchers have criticized diagnostic psychiatry for an individualistic and reductionist approach (Brinkmann 2016; Ehrenberg 2010; Frances 2013; Horwitz and Wakefield 2007) also when it comes to other disorders such as anxiety (Horwitz 2013).

The widely recognized and influential phenomenological philosopher Thomas Fuchs looks toward other cultures, in which individuals experience themselves as part of social communities, rather than as separate individuals, and emphasizes how the tendency worldwide is for patients to consult the doctor with *somatic* complaints, rather than psychological symptoms. He argues that a disorder like depression should be conceived as primarily bodily disturbances rather than as an inner, individual disorder (Fuchs 2013:220). Fuchs thus refers to cross-cultural studies on depression, showing that the somatic expression of depression generally has a higher prevalence in non-Western societies (Kleinman and Kleinman 2007:469; Marsella 1979). Inspired by Fuchs, I suggest that we do not only find examples that support this interpretation of

depression when we look at distant cultures. If we consider people suffering from depression in Denmark, a late-modern, individualistic society, it becomes clear how depression is experienced as bodily, social, and interpersonal processes, and not only as an intra-psycho brain disorder. However, this perspective is often neglected, leaving bodily experiences to be treated as a kind of second-rank passage.

Combining Fuchs' (2005a, 2013, 2014) and other scholars' phenomenological work on depression (Carel 2013; Fuchs and Koch 2014; Ratcliffe 2015; Svenaeus 2014) together with the sociological concept of body work (Elfving-Hwang 2016; Twigg et al. 2011; Ward, Campbell, and Keady 2016), I explore how we might understand depression as an embodiment that is out of tune and as an altered way of being in the world. Furthermore, I investigate how the body is worked on to reestablish attunement and to synchronize with the rhythm of everyday life. I thus add to the literature on depression by comprehending depression as a loss of bodily resonance, and by methodically using my own body as an instrument of resonance in the fieldwork and when mediating the findings from it in this article. This perspective calls for an acknowledgement of the resonant body, and provides a non-reductionist portrayal of depression that differs from the dominant understanding of depression, as primarily an inner and individual (brain) disorder.

The structure of the article is as follows. I start by describing the fieldwork that provides the basis for the article. Subsequently, I give a short overview of the phenomenology of depression, including the concepts of "the resonant body" and "bodily doubt." In the remaining parts of the article, I analyze depression as an out-of-tune embodiment, followed by an analysis of my informants' different efforts to regain control over their bodies. In closing, I briefly illustrate how the reestablishment of attunement is characterized by new ways of finding oneself in the world, manifested concretely in new subtle ways of living everyday life.

METHODOLOGICAL BACKGROUND: STUDYING DEPRESSION AND BODIES

The empirical foundation for this article is based on fieldwork on depression conducted in Denmark. The fieldwork started in September 2013 and took place continuously over a two-year period. As part of the fieldwork, I participated in monthly meetings in a voluntary support group hosted by a patients' association. I observed a 20-week group therapy course at an outpatient clinic, called a "depression group," with eight patients, facilitated by two psychotherapists. I spent a week as a volunteer

and an anthropologist doing fieldwork at a “summer folk high school” (“sommerhøjskole”)²⁹ in July 2014, in which adults suffering from depression and volunteers were gathered under one roof to try to “regain vitality” (“Genvind livskraften”), which was the title for the week. Moreover, I followed different news media dealing with depression and depression forums on Facebook, as well as reading memoirs. Finally, I interviewed two men and eight women about their experiences with depression. The multi-sided fieldwork offered me an opportunity to gain an insight into the complex empirical realities my informants inhabit. It has provided an appreciation of the horrible and multifaceted experiences of depression that have a tremendous effect on people’s lives and can fundamentally change their way of finding themselves in the world.

From my fieldwork, a striking aspect is how my informants’ accounts are filled with vivid portrayals of depression as a condition that profoundly disturbs their embodied being in the world. The interviews are packed with descriptions of how the body becomes agonizingly conspicuous in depression. My informants report on a tightening in the belly, unstoppable weeping and tears, a raised heartbeat, shivering and trembling, eyes that are switched off, clenching fists, troubled breathing, aching back pain, nausea, and headaches. Irene described it like this: “I felt dead in my face at that time. It was as if my cheeks were sleeping. I didn’t have any facial expression. Everything was just hanging because I was so exhausted and sad.” Parallel with descriptions of how depression is physically felt are accounts of an altered relationship with one’s body: The body “does not work on one’s side,” it becomes “an opponent,” it “says no,” it “cannot hang together,” it feels like “losing one’s body,” and as if “the body does not belong to me, anymore,” to give just a few examples. All things considered, depression is about losing control over one’s body: It becomes alienated, leading to an altered embodiment that is out of tune. As a consequence, my informants initiated various efforts to try to regain a sense of control over their bodies and to reestablish attunement.

The narratives I have heard in my fieldwork have furthermore been filled with long and heartrending stories about events triggering depression. Hannah and Rachel respectively recounted a sexual assault and a rape in their early teens—in both cases a trauma they told no-one about until late in life—leading to depression in adulthood. Others understand depression as caused by difficult life circumstances, such as the death of a loved one or a divorce, at the same time questioning the diagnosis of depression, and reflecting upon the boundaries between bereavement as a natural part of life and depression as a disorder. Others interpret depression as caused by them living their lives in a “wrong” manner: working too much (stress), not listening to their true

²⁹ Folk high schools are institutions for adult education that do not grant any academic degrees as they do not have any final exams. During a period of residence, the students stay at the folk high school day and night, engaging in a community with their fellow students. Folk high schools are characterized by a focus on self-development in different ways, and subjects are often related to the creative arts, sport, or more intellectual courses.

selves, being highly sensitive, and having organized their lives in unsuitable ways. It is important to stress that the informants' explanations are often a medley of different reasons. Moreover, it is not that they refuse to attribute any biological aspects to depression. Yet, the source of their depression is mainly to be found in the interpersonal, social and cultural world, according to their narratives. This quest for contextualized explanations differs from the tendency in diagnostic psychiatry to put depression "into an inner container" (Fuchs 2013:234), and attribute depression solely to the individual and his or her interior. It hints at how depression is often experienced as a very relational and bodily phenomenon, one that stands in contrast to the diagnostic portrayal of depression.

The findings from my fieldwork outlined above provide the empirical background for this article, in which I follow the paradigm of embodiment. This implies that the lived body is the primary domain of experience at a pre-subjective level. Thus, human beings are first and foremost bodily beings, in which any feeling of being is a bodily feeling in its essence (Carel 2013:180; Csordas 2014; Fuchs 2013; Jackson 1983; Lefebvre 2004; Merleau-Ponty 2012[1945]; Ratcliffe et al. 2014; Ratcliffe 2015). However, embodied experiences are also highly world-dependent, which means that our being in the world is naturally dependent on what happens in the world around us (Svenaesus 2014:1, 13).

Phenomenological work on depression is primarily based on readings of phenomenological philosophers, depression memoirs, and questionnaires (Carel 2013; Ratcliffe 2015; Svenaesus 2014), and from consultations with patients (Fuchs 2014). While I am indebted to this work, and use the concepts and lines of thought in this article, I nevertheless supplement it by using bodily interactions from the fieldwork and my own bodily sensations from being with my informants as data. Methodically, it is difficult to gain access to embodied experiences, especially when studying experiences that sufferers often depict as indescribable and impossible for others who have not experienced depression to understand (Jamison 1997:174; Karp 1996; Ratcliffe 2015:1–2; Styron 1990; Trivelli 2014). Yet, one of the benefits of doing ethnographic fieldwork and spending time with people suffering from depression is that bodily interactions offer a different kind of access to embodied experience than verbal communication and the written word (Nielsen 2017:262). In different situations in the fieldwork, both in the interview settings and during observations, I felt my own sense of attunement challenged from time to time. I will include my own bodily sensations from being with my informants in the following analysis to illustrate what my informants were telling and showing me in terms of loss of bodily resonance and bodily doubt. I claim that this empirical foundation can, with its thick ethnographic description, provide a more vivid portrayal of how depression is experienced as an out-of-tune embodiment, and in this way flesh out phenomenological work on depression. Inspired by anthropologist Ruth Behar, it is furthermore an attempt to be open about the vulnerability inherent in ethnographic fieldwork, and to use this to "take us somewhere we could not otherwise get to" (Behar 1996:14) by making both my informants and myself vulnerable in the text. Using my own body as an instrument of resonance is thus a stylistic

attempt to “write with resonance” (Meier and Wegener 2017), hopefully mediating a better *sense* of what depression feels like and create an echo in the reader.

Before I go in depth into how depression unfolds as an embodiment that is out of tune in my fieldwork, I provide an introduction to the phenomenology of depression and the resonant body.

A PHENOMENOLOGY OF DEPRESSION: THE RESONANT BODY

The philosopher Matthew Ratcliffe has developed a phenomenology of depression, in which he argues that it involves a disturbance, or even a complete loss, of the sense of “being comfortably immersed in the world” (2015:15).³⁰ The painful experiences of depression can transform one’s relationship with the world, so that the world comes to look different, and things that used to be familiar are somehow suddenly strange and distant (Ratcliffe 2015:78). Depression is also about disconnection, isolation, and withdrawal, as the American sociologist David Karp (1996) portrays in his interview study on depression. An insistent theme in every interview centers on depression as a lack of connection with oneself and others. Depression is furthermore about loss of hope, feelings of guilt, “changes in emotion, thought, and volition” (Ratcliffe 2015:166), a feeling of non-feeling (Fuchs 2013:228), and a fundamental desynchronization in temporal perception (Fuchs 2005b; Ratcliffe 2012). These phenomenological themes all depict how depression is experienced as an altered way of being in the world, in which the “sense of lived body, lived space and being-with-others” (Fuchs 2013:222) is changed. These are all topics that I too recognize in my fieldwork. Keeping the complexity of depression in mind, I primarily approach depression from an embodied perspective.

As bodily beings, we have an automatic coherence with the environment, a sense of connection that incorporates a taken-for-granted and pre-reflective sense of “belonging to a shared world” (Ratcliffe 2015:2). We follow a specific rhythm in our being in the world, in which we participate in a shared space of *attunement*. To be attuned is when body, self, and environment are tuned to a common chord, “similar to a tonality linking a series of notes and chords to the major or minor key,” establishing a “consonance of bodily feeling, emotion, and environmental atmosphere” (Fuchs 2013:224). “The closest we might come to describing what it means to be attuned is captured in the experience of how a piece of music sucks us into a pervasive mood, which colors our entire being-in-the world” (Svenaesus 2014:10), hinting at how associations to music might be the most adequate vocabulary in trying to capture what depression feels like.

³⁰ Ratcliffe’s work is based on his readings of phenomenological philosophers, published depression memoirs, and an Internet questionnaire he conducted in 2011 with colleagues, in which 145 participants wrote text responses with no word limit (Ratcliffe 2015:26–27).

The sense of attunement goes more or less unnoticed in daily life because we are underpinned by a powerful faith in which we feel confident “that our bodies will continue to function in a similar fashion to the way they have functioned in the past” (Carel 2013:181). It is in states of illness and disturbances that the attuned body becomes *detuned* and in discord, and comes to the foreground (Fuchs 2005a, 2013, 2014; Leder 1990; Ratcliffe 2012:116). The depressive body “turns into a barrier [...], resulting in a general sense of detachment, separation or even expulsion” (Fuchs 2013:222). This is felt in a literal sense, as a failure of bodily attunement to the world and others. There is a “mismatch between one’s bodily capacity and the task one faces” (Fuchs and Koch 2014:3). As one of my informants, Tina, described a daily task: “Even cooking seemed like climbing Mount Everest.” This is experienced as such “*through* the tired, incapable body” (Fuchs and Koch 2014:3). Thus, the depressive body is a *detuned*, restricted body that is painfully out of joint, desynchronized from the world that is shared with others; it is altered into an alienated and foreign body filled with “bodily doubt.” The philosopher Havi Carel uses this concept, bodily doubt, to capture how the tacit feeling of “bodily certainty,” is disturbed in cases of illness. She describes how the subtle feeling of “I can” is replaced with “a physical sensation of doubt and hesitation arising in one’s body” (Carel 2013:188), leading to a disruption in one’s most fundamental sense of being in the world. Once experienced, bodily doubt leaves a permanent mark on the person experiencing it (Carel 2013:186). Thus, bodily disturbances can lead to modifications of experiences, not only in relation to bodily experiences, but in an overall altered way of being in the world, also affecting identity and sense of selfhood.

When bodies become conspicuous and corporealized, Fuchs speaks of detunement of the resonant body. The resonant body is a kind of sensitive sounding board, in which every emotion and “interpersonal and other ‘vibrations’ constantly reverberate” (Fuchs 2013:223). The lived body is, in other words, to be understood as an instrument of resonance (Svenaesus 2014:13), picking up moods and vibrations from the world that is shared with others. The lived body has a capability to be affected by the world in getting tuned (and also out of tune), and in this way the resonant body mediates our attunement and participation in the social world, and connects us with others. Thus, bodily resonance can alter in a variety of ways, depending on what happens to the person in his or her being in the world (Svenaesus 2014:14), emphasizing intersubjective and social elements in how our experience of our bodies happen in reference to others. Fuchs uses the term “inter-bodily resonance” to capture how our bodies can be in accord or discord with one another, depending on the other’s bodily resonance and the atmosphere in a given situation (Fuchs 2013:223). This line of thought draw parallels with the anthropologist Tim Ingold’s thinking on how “the resonance of movement and feeling stemming from people’s mutually attentive engagement” (2002:196) is the very foundation of sociality, using the interplay of an orchestra as an example, in which “the gestures of the performers may be said to resonate with each other” (2002:196).

With these associations to music in mind, in what follows I will illustrate how depression is characterized by loss of bodily resonance and use my own bodily sensations “as a tacitly ‘felt mirror’ of the other” (Fuchs 2005a:98).

DEPRESSION: WRAPPED IN CLING FILM

Tina is 44 years old, and describes herself as having been a very active and committed person before the depression set in. She used to be very engaged in the local community where she lives with her family. In her small town, everybody knows who she is and the teachers at her two children’s schools used to be very fond of her. Then she started to feel depressed, withdrew, and isolated herself in the home. Now, she avoids doing the groceries in the local supermarket because she fears running into someone she knows. She is ashamed of herself and thinks she is “of no value for others” because she is no longer able to be “this energetic and sparkling person” she used to be. When I asked Tina how it feels to be depressed in her body, she gave this very vivid depiction:

My body has a complete lack of energy. It sleeps. It’s heavy. When I try to go for a run, it is like having lead in my legs. Tired, tired, tired. When I try to think about how it feels, the closest I can come up with is that of being wrapped in Velcro – you know, the plastics you wrap around food that binds off. I compare it with, when I’m feeling good, and nevertheless get into a stressful situation, and I put on that coat that says: “now I’m going to get through this professionally, right.” And then I get through it. But that coat seems to get kind of stuck when you have a depression, like VitaWrap [cling film]. You cannot get it off! And you cannot do *anything*. I had a period in which, not that I’ve been obsessed with showering or anything like that (apologetic smile in her voice), but it occurred to me that: “Oh, if I could just wash this *black, heavy* off.” But you can’t. And it’s extremely frustrating [...] Sometimes, I thought: “Now, I’m going to take the car and drive south—because then it might fall off! But it may just not! So it sits around you like, yeah, VitaWrap [cling film]. You cannot... You cannot *breathe*. Thus, you cannot live. And that’s how it feels. You are in a bubble and others are outside and you can’t push through. It is claustrophobic. You are trapped in your own body.

During the interview, I noticed how Tina sat with her arms crossed while we talked. Her eyes were dimmed and her back sunken. She looked down when I tried to meet her gaze and I wondered if she found the situation uncomfortable. She told me in a tearful voice how she broke with her parents nine years ago because of a terrible incident. It has still not been clarified whether this incident took place or not, and the consequences of her potential mistake haunts her. Afterwards she laughs ironically. I cannot help but think “she looks small, ashamed, and in profound pain,” as I wrote afterward in my field notes.

For Tina, depression literally feels like wearing a close-fitting coat, made out of cling film, impossible to either strip or wash off, no matter how hard she tries. Painful vibrations, from the world that is shared with others, have invaded her way of being in the world, leading to a sense of this omnipresent film, leaving her with a heavy body, out of tune.

The meeting with Tina was challenging. Her pain, shame, and self-reproach, were so permeating, and she seemed as if she were wishing herself far away. I was moved by her agony and her desperate situation. Yet I felt awkward in the interview setting, unsure of how to handle it. I started doubting whether my questions and responses were good enough, suitable. I remember thinking about where to let my glance dwell, holding my breath, straightening my body up, and clutching the notebook and pen in front of me. I tried to resist the temptation to reassure Tina that better times may be on the way. I felt an urge to do something, to release her from suffering; at the same time, I tried to remember how annoying encouragements can seem when you are in an indescribably dark abyss. So I just tried to stay there with her, and listen to this fragile stranger, who so vividly and openly revealed her pain to me. At the end of the interview, we agreed that I would contact her by email for the purpose of a new interview.

At one point in the interview, I remember asking Tina if she was okay. She assured me that she was. She paused, and then she looked at me and asked if *I* was okay, affected, as I was, by the heavy atmosphere in the living room. I remember lying, assuring her that of course I was okay, while fighting back the pressing tears in my eyes, trying to be professional. When walking away from her house, I remember thinking that I did not do well in that interview. I thought about what I could have done and said differently. I felt somehow ashamed of my performance (or lack of it); at the same time, I hoped that Tina was not hitting herself over the head because of her performance in the interview, which I sensed was a risk. I felt it was my mistake, that I was a bad interviewer if I had failed to assure her that she did perfectly well, which she did. A couple of days later, I contacted Tina via email and thanked her for the interview. She never wrote back.

How can we understand this? There is no doubt that I faced a difficult task and was deeply affected by Tina's desperate situation, which affected my bodily resonance as well. Following Fuchs and Koch, interactions are characterized by "a circular interplay of expressions and reactions [...] running in split seconds and constantly modifying each partner's bodily state" (2014:6). There is a feeling of one's own movement into the other: a mutual bodily interchange, in which Tina's body extended to mine and mine somehow extended to hers (Fuchs and Koch 2014:6). Fuchs and Koch call feelings of being connected with the other "mutual incorporation" (Fuchs and Koch 2014:6), so there is a risk of being in discord with others and inter-corporeal *dissonance*. Bodies can be tuned or detuned, in accord or discord. I felt out of tune in general during the interview, and by turns both connected and disconnected with Tina. As uncomfortable as it was, this might provide a glimpse into how the resonant body can be disturbed, or even permanently altered, in depression by painful vibrations,

leading to bodily doubt and an altered way of being in the world from which it can be impossible to escape. After a couple of days, the uncomfortableness following the interview disappeared from my body. I wonder how Tina is feeling these days and hope she has managed to escape the close-fitting cling film.

RE-ESTABLISHING BODILY RESONANCE THROUGH BODY WORK

I now turn to investigating how bodies are worked on to try to re-establish or alter bodily resonance and re-attune to the rhythm of the everyday.

The many different attempts to try to adjust out-of-tune bodies in my fieldwork have been noticeable. My informants longed to regain a sense of bodily certainty and a feeling of being immersed in the world. Thus, they attempted to recapture control over their bodies, emotions, feelings, and thoughts by various means, such as medicine, consultations with a clinical psychologist or psychiatrist, group therapy, healing, exercise, diets (e.g., avoiding sugar and alcohol), herbal remedies for sleep, listening to calming raindrops on their smartphones, yoga, mindfulness and relaxation exercises, sick leave, new hobbies like walking a dog, going fishing or hunting, gardening, light therapy, fresh air, laughter and light, spending more time outside, maintaining a stable circadian rhythm, slowing down in general by doing less and spending more time alone. All these endless efforts are attempts to try to manage depression through what I call *body work*, which are different efforts to work on one's body. Some of the means my informants were using were to a greater extent more directly aimed at the body than others. However, here I understand these many attempts as different ways of trying to re-attune to the rhythm of the everyday through their bodies.

Phenomenological studies on depression are preoccupied with experiences of depression and not as much with what people *do* to regain bodily resonance, which is my concern here. Fuchs (2014) mentions that the therapeutic process is about re-synchronizing being and giving rhythm to everyday life. He outlines some general guidelines that a "psychosocial resynchronizing therapy" should take into account, for instance the importance of repetition and regularity in the structure of the day and week (Fuchs 2014:410). However, he does not explore what sufferers *do* in their daily lives to recreate their participation in the shared space of attunement. Thus, I consider it necessary to introduce the sociological concept, *body work*. Body work is in particular used to investigate labor "done 'to', 'on' or 'for' a body by another" (Ward et al. 2016:1299). This perspective emphasizes the social relations of working on others bodies in areas such as body-pleasing trades, for example hairdressing and massage (Ward et al. 2016), and more controversial fields like sex work (Twigg et al. 2011). The concept has also been used within the field of ageing research to understand personal beauty practices among elderly South Korean women (Elfvig-Hwang 2016), to give an example that emphasizes how individuals work on their own bodies. In this article, I primarily understand body work as efforts undertaken by individuals on their bodies, thereby also a kind of working on the self (Twigg et al. 2011:2), including one's emotions, feelings, and thoughts, in that body and self are inseparable. In this

understanding of body work, I am inspired by the sociologist Michael Flaherty's concept of "time work," which concerns efforts "to promote or suppress a particular temporal experience" (2003:19), and the sociologist Arlie Russel Hochschild's concept of emotion work, in which working on an emotion is to manage an emotion (1979:561). Body work, as I understand it in this context, thus entails attempts to try to manage and (re)gain control over bodies, and to rebuild bodily certainty.

The most widespread way of treating depression in Denmark is incontestably pharmacological treatment, which is also the main recommendation of the Danish health authorities in combination with psychotherapy (Sundhedsstyrelsen 2007).³¹ Beyond this, there is also a vast array of unofficial advice and ways of working on depression circulating among lay people, including my informants, as mentioned previously. In what follows, I will explore three different kinds of body work from my fieldwork: antidepressant medication (because of its widespread usage), a stay at a folk high school (in which the importance of collective efforts in recovering from depression is emphasized), and finally mindfulness (which is interesting because of its direct focus on attuning through the body). These three kinds of body work can demonstrate the difficult and painful processes of re-creating bodily resonance and coming to terms with a new way of being in the world in different ways.

A MEDICALIZED RESPONSE TO DEPRESSION

One of the most widespread ways of trying to recover from depression in my fieldwork was through the intake of medication. The purpose of antidepressants is, in simplified terms, to alter the concentration of neurotransmitters in order to lift the mood and re-establish activity. My informants' experience of taking medication varied greatly. Some questioned its effectiveness, a few reported not being able to feel any effect at all, and others found it helpful despite the difficult side effects. Peter, diagnosed with moderate depression, described his experience with medication as follows:

Peter: It was as if they [the medications] put a filter, or like putting a cloth in front of a speaker. All the bad impressions that pushed themselves forward became a little more muted, but you could also get a little more immune to all the good impressions. Something like music, which you previously felt very excited about, or just really hit the mark... It didn't do that anymore.

Me: But do you find the medicine helpful?

³¹ The newest clinical guideline from The Danish Health and Medicines Authority also mentions physical activity, mindfulness, fish oil, and light therapy as strategies for treating depression. However, they stress that there is insufficient evidence-based documentation to recommend these as official methods of treatment from official quarters (Sundhedsstyrelsen 2007).

Peter: Good lord! It is not a miracle drug. Nothing is. But it helps me to be able to consider things. Like, I can sit and have this conversation, whether it's with a stranger or the psychologist. My doctor or my friends. And it gives me... It gives me a little more in the daily round. There is still a long way to go. I haven't cleaned much the last couple of months, and it's difficult to do regular daily routines. Make sure that you make a proper dinner. Make sure to dust the furniture. Make sure of this and that!

Peter's depiction of his experience of taking medication has an ambivalent character to it. He reports that the medicine helps to moderate disturbances from the surrounding world, for good and bad, just as it gives an impetus to start carrying out the daily activities that have been put on pause for quite a while. In this way, he experiences that the medication, to some extent, alters his bodily resonance, which has been detuned or even lost during the awfulness of being in midst of depression. He believes it is the medicine that is slowly making him more able to start gradually following the rhythm of the everyday again by slowly making him able to resume interactions with others. Later in the interview, he reflected on how the experience of illness had made him more careful in how he engages with the world. He operates with a "before and after" depression, which is typical among sufferers (Carel 2013; Karp 1996; Svenaeus 2014). He now makes fewer plans during the week, and he spends more time alone compared to how things were before he became depressed. The terrible experience of illness has, in other words, marked him with a greater cautiousness and slowness in his way of being in the world.

ATTUNEMENT AS A COLLECTIVE EFFORT: AN INTENSIVE WEEK OF BODY WORK

Another way of working on the body is to sign up for a week at a folk high school, which focuses on giving the participants "zest for life." It is important to highlight that this "treatment option" is quite unusual. Nonetheless, the folk high school is interesting to explore as it is a practice that combines individual body work with an emphasis on the importance of communities, social relations, and care in re-establishing bodily resonance. Thus, I understand the folk high school as an intense week of body work aimed at altering bodily resonance, and enabling "the attunement of the person and thus the person's being in the world" (Svenaeus 2014:13) through a combination of individual and collective efforts.

A central idea behind the organization of the folk high school is that it is no use simply being given good advice, as the leader of the folk high school explained to me. Thus, the program is structured in a way so that course participants will try out good advice on how to deal with depression in practice, e.g., maintaining a stable circadian rhythm, a healthy diet, and regular exercise. Thus, the program encourages the course participants to go to bed at 10 p.m. every evening. The next day starts at 8 a.m. with a morning activity; participants can choose between yoga, cycling with a combined dip in the sea, or a walk or a run. Later every morning different talks on depression are

scheduled and there are activities every afternoon, such as singing in a choir, jewelry workshop, horse riding, and outdoor events. The food is healthy and varied, and they do not serve any alcohol. Thus, the program, or the “mini-laboratory,” as the leader calls it, presents recommendations on how to treat and live with depression, and engages the participants in trying out this advice with their own bodies. Nevertheless, some of the participants told me that they stayed up till 1 a.m., playing backgammon, the turnout at the morning activities was moderate, and the volunteers complained that the participants bought beer at the local supermarket. The hope is, nonetheless, that the participants will incorporate some of these recommendations in their daily habits when they return home.

A defining characteristic of the participants was that they described themselves as lonely and isolated. Furthermore, they found it challenging to participate in a week like this. For instance, Anne, a woman in her late forties, who I met in the parking lot the day the participants arrived, hesitantly told me that she had thought about attending the folk high school for the last four years. This year, she finally found the courage to do it. I asked what she did for a living, trying to engage in conversation, and she replied that she had tried to complete a couple of educational programs with no luck and had taken early retirement. “That is how it is,” she said in a monotonic voice, smiling nervously, squeezing her lips together, and staring at the ground. I found it difficult to talk with her. She responded to my questions monosyllabically and I had the feeling of interrogating her, so I ended the talk and directed her to check-in. That same night, I was looking out of the window in the auditorium, watching Anne standing in a circle with about ten other participants, doing some kind of silly ice-breaker. They were all doubled up with laughter, but Anne seemed to be especially amused. She was folded up, slapping her thighs while guffawing and weeping with joy. She seemed almost hysterical or just out of control, nearly hyperventilating. I watched Matthew, the volunteer responsible for the ice-breaker, walk toward her, gently put his arm around her shoulders, smile, and ask her if she was okay. She nodded, while wiping away the tears of joy with her hand, holding her arms on her chest, taking deep breaths, and trying to control her laughter, while assuring Matthew that everything was fine. I interpret this as indicating that Anne was positively overwhelmed by being part of the community at the folk high school—a striking contrast to her usual isolated everyday life—thus finding herself grinning and laughing in an uncontrolled but pleasant way.

To try to deal with the fact that many of the participants return to an isolated life, the dedicated volunteers made an effort to facilitate new friendships among the participants, and create more permanent networks based on where the participants lived geographically. Following the Facebook group, in which activity was high immediately after the week was over, I could tell that they were to some extent successful with this. However, after a while the activity faded.

MINDFULNESS: LEARNING TO LISTEN TO THE BODY

A common factor among some of my informants is the understanding of depression being triggered because of long periods of not “listening to what the body told them.” Therefore, they have to learn to listen to their bodies in order to re-establish bodily resonance and to keep recurrent bouts of depression at bay. One idea of how this can be accomplished is through practices like mindfulness, yoga, and relaxation exercises, about which several of my informants talked enthusiastically in the interviews.

Mindfulness is a practice derived from ancient Buddhist and yogic traditions, and has become increasingly popular both in and outside clinical settings to treat depression, among other things. Briefly put, mindfulness refers to “a process that leads to a mental state characterized by nonjudgmental awareness of the present moment experience” (Hofmann et al. 2010:2). Furthermore, it encourages openness, curiosity, and acceptance of one’s bodily and emotional state. One of the ideas behind mindfulness is that slow, deep breathing and a specific awareness focused on the body can alleviate the bodily symptoms of distress, and “alter the intensity or frequency of unwanted internal experience” (Hofmann et al. 2010:2). In what follows, I thus understand mindfulness as body work aimed at making friends with one’s body, re-establishing bodily certainty, and again attuning the body to the environment.

When talking about mindfulness in interviews, my informants described it as learning “to feel the body more,” “to get down in the body,” thereby also learning “to listen to the body’s limits,” “to what the body is saying,” and “to make sure I’m not in my head all the time but in my body.” It is also about learning to have “a sense of yourself,” “to feel your gut feeling and be able to feel when something is enough,” as Bridget put it.

In the following excerpt, Hannah recounts one of the first times she attended a yoga class for people suffering from depression:

I lay down and cried in both mindfulness and yoga the first times I was there. So, I really couldn’t stand being there and my thoughts took up too much space... [...] You know, it wasn’t a normal yoga class. Everyone was sick (laughing a bit) and the teachers were used to it. So I was put into a restorative position, and then she came and caressed my cheek and put a blanket around me. It was *definitely* what I needed... [...] I have read a lot of books [about depression], I have been taught and seen a psychologist. So I just thought that my brain was packed. My problem was that I couldn’t get it down in my body.

Mindfulness is an attempt to make friends with the body, which has become foreign in the midst of depression. It also part of a process of regaining control over the body, trying to turn it into an ally and alleviate the experience of the body as an entity that has a life of its own. Furthermore, as recounted by my informants, learning to listen to the body involves processes in which they gradually start to do things differently.

Some of them started by living at a different and slower pace; in other words, they did not necessarily return to how things were before the depression started, but rather started something new.

Thus, mindfulness and the other kinds of body work in my fieldwork are part of various efforts to come to terms with a new way of being in the world. This is more concretely expressed in certain everyday changes; for example, some of my informants reported working fewer hours than before, changing their diet, starting to exercise or making a change in the kinds of sports they engaged in (Bridget switched from marathons to yoga and bicycle rides), lowering their level of activity in general, and adjusting their dreams of the future (Sarah, for instance, abandoned her dream of a third baby). A change can, in other words, occur in how one finds oneself in the world, including the sense of bodily certainty, as well as identity and selfhood (Svenaeus 2014:8). There is “no turning back once genuine bodily doubt has been experienced,” to paraphrase Carel. “One’s basic orientation in the world has changed and the possibility of catastrophic bodily failure is now part of one’s horizons” (Carel 2013:186). Thus, bodily disturbances can lead to modifications of experiences, in particular in relation to bodily experiences, but also in an overall altered way of being in the world, affecting identity and the sense of selfhood, and how daily life is lived.

CONCLUDING CONSIDERATIONS

In this article, I have provided a portrayal of how depression unfolds as a bodily and relational phenomenon in the everyday life of people suffering from depression. More precisely, I have approached depression as a problem of attunement and a loss of bodily resonance, in which lived embodiment is experienced as out of tune. I have furthermore investigated what sufferers do with their bodies to try and re-create bodily resonance by different kinds of body work.

My intention has been to show how depression in the daily lives of sufferers is primarily experienced as bodily disturbances, in which the body no longer resonates. Thus, the article is a supplement to the dominant diagnostic understanding of depression, as primarily an inner and individual (brain) disorder, highlighting how depression also unfolds as a bodily and relational phenomenon in quotidian life. This perspective especially emphasizes embodied but also relational aspects of depression, and calls for an acknowledgement of the resonant body as a sensitive sounding board, as well as pointing to the importance of inter-bodily resonance and inter-corporeal dissonance, when studying embodied experiences of health and illness (Fuchs 2013; Fuchs and Koch 2014; Nielsen 2017). It furthermore hints at a discrepancy between biomedical accounts of depression and the quest for contextualized explanations among sufferers, an aspect which it would be interesting to explore further.

An individual approach to depression obviously fosters individual understandings of how depression is to be treated, as well as prevented. The kinds of body work I have

described in the article, the intake of medication, the importance of a stable circadian rhythm, a healthy diet and regular exercise, and mindfulness, are all individual acts of trying to re-establish bodily resonance. Yet, the folk high schools' emphasis on solicitude and communities hint at the importance of relational aspects in re-creating attunement in relation to the body/self, others, and the world.

In relation to methodology, the article has been an attempt to “write with resonance” (Meier and Wegener 2017), and to give the reader a better sense of how depression is experienced by using my own body as an instrument of resonance (Svenaesus 2014). The purpose of making myself vulnerable in the text has been to try to mediate how depression is experienced as an out-of-tune embodiment by putting my own sense of detunement in the fieldwork forward. I suggest that an awareness of inter-bodily resonance and one's own bodily sensations when doing and writing fieldwork can provide a launch pad to mediate a more vivid and lively portrayal of how depression and other embodied experiences feel. More concretely, this can be done by choosing to have a specific focus on bodies when carrying out fieldwork. For instance, we can choose to focus on how our informants move with their bodies, including how they speak, their timbre, rhythm, characteristic pauses, and gestures, and the feelings stirring in us as we listen, watch, and participate (Jackson 2012; Narayan 2012). The aim is not necessarily to understand a phenomenon completely because this is hardly ever possible, as is the case with depression. The purpose is rather to get a better *sense* of what experiences feel like. The purpose is, in other words, to paraphrase the anthropologist Renato Rosaldo, “to bring its subject – whether pain, sorrow, shock, or joy – home to the reader. It is not an ornament; it does not make things pretty. Nor does it shy away from agony and distress. Instead it brings things closer, or into focus, or makes them palpable” (2013:105).

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CHAPTER 10. CONCLUSION

In this thesis, I have examined adults' experiences of depression in everyday life. I have studied aspects of life with depression, embodied experiences of depression, and the multifaceted and ambiguous experiences of getting a depression diagnosis, including the processes of "learning to live under the description" (Martin, 2007) of depression in everyday life. It has been my ambition to learn about and analyze experiences of being diagnosed with depression and to study the meanings people attach to the diagnosis of depression within the context of our time, culture and dominant ways of understanding suffering in contemporary diagnostic cultures.

Experience is a central concept in the thesis, insofar as I have studied adults' experiences of depression and diagnostic processes. I have done this by paying attention to intersubjective, corporeal, social and cultural dimensions of my informants' lives, as I understand experience as socially and culturally embedded. In this way, I follow medical anthropology's long phenomenological-inspired tradition of studying the meanings people attach to illness experiences and the macrosocial processes that impinge on it.

Three research questions have guided my study, namely 1) How does depression unfold in everyday life, and how is the condition experienced among adults diagnosed with depression? 2) How do adults diagnosed with depression negotiate, navigate, and interpret a diagnosis of depression? And 3) How do adults experience the process of being diagnosed with depression, and how do they learn to live under this particular diagnostic description?

In order to study these research questions, I have conducted an ethnographic fieldwork in Denmark among adults diagnosed with depression. The fieldwork has provided first-person accounts of living with depression. Participating in and doing observations in different field sites centered around depression have furthermore provided valuable insight into the world of depression. The empirical material is more specifically created from participating in and observing meetings in a volunteer-based support group hosted by a patients' association, from spending a week at a summer folk high school for people diagnosed with depression, and from observations in a depression group led by two psychotherapists at an outpatient psychiatric department. Moreover, I have interviewed eight women and two men about their experiences of depression and of living with a depression diagnosis in everyday life. Lastly, I have followed the media coverage of depression and depression fora on Facebook.

As depicted previously in the thesis, research on depression is vast, ranging from work that deal with the phenomenology of depression based on mainly philosophical reasoning, and macro sociological perspectives on multiple determinants to why so many people are haunted by depression in contemporary time. When it comes to qualitative

work with an explicit diagnostic perspective on depression based on first-person accounts, there are remarkably few studies. There is, in other words, sparse qualitative research that investigate how adults diagnosed with depression experience diagnostic processes, and how they understand, interpret and enact a diagnosis of depression in everyday life. There is furthermore a lack of literature that explicitly deals with the complex processes involved in learning to live under the description of depression in everyday life. The purpose of the thesis is to contribute to remedy this lack.

The three articles offer different accounts of the process of being diagnosed and living with depression in everyday life. The first article, “Struggling with a depression diagnosis: Negotiations with diagnostic categories” examines how processes of learning to live under the description of depression can involve multiple relations to the diagnosis, and how they can be messy, changeable and complicated affairs. The second article, “Living under a Diagnostic Description: Navigating Images, Metaphors and Sounds of Depression” points to a creativity and variability in how people can relate to, interpret and make use of a diagnosis of depression in everyday life by drawing on cultural repertoires on depression. Finally, the third article, “Depression: Out-of-Tune Embodiment, Loss of Bodily Resonance, and Body Work” examines how depression is experienced as a very bodily and relational phenomenon where the body no longer resonates with the rhythms of the outside world.

Article 1 and 2 have mainly answered my second and third research questions about how adults navigate, interpret and negotiate a diagnosis of depression, as well as the complex processes involved in learning to live under the description of a depression diagnosis. Article 3 has primarily answered my first research question about how depression unfolds in everyday life.

In the next, I will outline the contributions, conclusions and arguments of each of the three articles in the thesis and summarize the general findings. Finally, I sketch avenues for future research on experiences of depression and diagnostic processes.

10.1. STRUGGLING WITH A DEPRESSION DIAGNOSIS (ARTICLE 1)

As depicted previously, qualitative studies of experiences of being diagnosed with a psychiatric diagnosis in general, and with depression in particular, tend to agree that these are characterized by a transformation of sense of identity and self. The literature furthermore depicts how a diagnosis offers an interpretive framework for understanding suffering, as well as legitimization of illness experiences. Furthermore, an ambivalence characteristic of diagnostic processes, as well as an inadequacy of diagnoses to sufficiently depict suffering, is also often portrayed. These implications of a diagnosis

are all present in my fieldwork. However, although these are indeed important insights, there is a tendency within the literature of drawing too simplistic conclusions to depict the complex empirical realities people inhabit. More specifically, I find that the literature tends to line up too neatly ways in which people experience a diagnosis as *either* stigmatizing, explanatory *or* as legitimizing. I claim that this very structured and systematized way of representing experiences of diagnostic processes do not provide a faithful picture of the messiness that characterize experiences of living with a diagnosis in everyday life.

On this background, article 1 is an attempt to nuance and qualify the discussion of individual experiences of living under the description of a depression diagnosis in everyday life by following the life and words of a single person, Bridget. The purpose of the article is to provide a non-reductionist portrayal of how the same person can use and experience a depression diagnosis in a range of changeable, messy and sometimes even contradictory ways. A central contribution of the article is thus to provide an account of what it feels like to live with depression in everyday life by emphasizing the complex and changeable relations the same person can have with a diagnosis. The aim of the article is, in other words, to illustrate how diagnostic processes are not once-and-for-all-dealt-with matters, but rather messy, complicated and variable processes that involve several actors and multiple relations to the diagnosis over time. I am thus adding to the literature on diagnosis by offering an in-depth description of one of my informants' multifaceted, chaotic and changeable relation to the depression diagnosis.

The article furthermore contributes to the diagnostic literature by giving voice to a person's resistance against being pathologized and stigmatized through a diagnostic labeling. By focusing on the theme of resistance and dispute in diagnostic processes, the article contributes with a theme which is sparsely represented in the literature.

In the article, I suggest that the contemporary unattractiveness of depression, where depression is the negative definition of the current normative expectations of how we ought to be as persons in order to succeed, is a central factor to Bridget's initial refusal of the diagnosis. The negative sound to depression makes it difficult for her to subscribe to a diagnostic understanding of her suffering, insofar as it does not resonate with the image she has of herself.

Bridget's narrative demonstrates the dominance of diagnostic categories and a bio-medical gaze when a person is to make sense of illness experiences in Denmark. This is not to say that other categories and languages are absent in contemporary diagnostic cultures. In Bridget's case, she came across the category of being a Highly Sensitive Person, which illustrates how other languages and categories *do* exist. There is furthermore a selective element to what Bridget eventually uses from the category of depression, which points to a variability and creativity in how people can use and

relate to a depression diagnosis in everyday life. However, in Bridget's case, the diagnosis of depression slowly enters her self-understanding after a while, as I depict in the article. This demonstrates how difficult it is to stick to an understanding of suffering that differs from a diagnostic understanding in contemporary diagnostic cultures.

10.2. NAVIGATING CULTURAL REPERTOIRES ON DEPRESSION (ARTICLE 2)

As depicted previously, several researchers have expressed concerns about the current dominance of a diagnostic language, brain-based explanations of mental illness, and biomedical discourses (Brinkmann, 2016; Csordas, 2014; Good et al., 1992; Karp, 1996, 2006; Kleinman, 1988a; Jenkins, 2015; Martin, 2007, 2010; Rose, 2007). These researchers problematize in different ways the potential impoverishment, loss and reductionism that follows from these dominating ways of understanding human suffering in contemporary time. However, in-depth explorations of the processes involved in learning to live under the description of depression in everyday life are lacking. There is furthermore sparse research that depicts how people use a diagnosis of depression in everyday life, including the potentially impoverishing consequences of the diagnostic language. The purpose of article 2 is to contribute to fill out this gap.

Regardless of the immediate response to the diagnosis, it is common in my fieldwork that my informants experience the diagnosis of depression as a rather diffuse and intangible clinical entity. As a consequence, a process starts where they try to familiarize themselves with the diagnosis to understand what depression is about after the diagnosis has been given. During the fieldwork, I noticed that cultural repertoires of depression in the form of metaphors, images, and sounds played a significant part in this process. I also found it striking how the informants had multiple ways of understanding the term depression and a range of ways of making sense of the diagnosis. This eventually led me to examine the role of cultural repertoires of depression in diagnostic processes.

In article 2, I have more specifically investigated how my informants use metaphors, images and sounds of depression in the process of learning to live under the description of depression. I argue that metaphors, images and sounds play a significant part in the process of transforming a clinical diagnosis of depression into images that resonate with illness experiences and unique lives. In this way, cultural repertoires of depression work as a kind of mediators, I argue, that contribute to transform clinical diagnoses into images the diagnosed person can identify with.

On this background, I suggest that cultural repertoires of depression provide a space for a kind of inventive play with the diagnosis that enable unique life stories and lived experiences to be bridged with the clinical diagnosis of depression. This points to a selectivity and creativity in how people relate to a diagnosis in present-day diagnostic

cultures.

10.3. OUT-OF-TUNE EMBODIMENT AND BODY WORK (ARTICLE 3)

“...I usually find it more manageable to think of depression as a social construct, an ache that does not *really* belong to this body, a cultural label, a disembodied clinical entity [...] But even when immersed in abstraction, the body makes its call. The body aches, in and beyond any *discourse* on ‘depression’ (Trivelli, 2014: p.152).

Elena Trivelli, who suffers from depression and who takes antidepressant medication, has written an auto-ethnographic article on living with depression. In it, she engages with different perspectives on depression. Many of these are based on social constructivism that approach depression as a discursive and social construct. Others are based on capitalism critic. Regardless of how right these perspectives might be in certain respects, at the end of the day, depression is a fundamental bodily experience where the “body makes its call”, Trivelli writes, and where the body aches uncontrollably. Similar to Trivelli’s depiction of depression, it was striking in my fieldwork, how my informants’ accounts of experiences of depression were packed with descriptions and metaphors that referred to specific bodily sensations when they accounted for their experiences of depression. On this background, my third article is driven by an aspiration to examine these bodily sensations in depression (rather than the diagnosis of depression).

In this article, I have borrowed concepts from the phenomenology of depression to explore depression as an out-of-tune embodiment, characterized by disturbances of bodily experiences and loss of bodily resonance. Following in the footsteps of Thomas Fuchs, the article also emphasizes intercorporeal and intersubjective aspects of experiences of depression.

The article offers an alternative to the dominant understanding of depression as primarily an individual brain disorder by illustrating how depression is experienced as a very bodily and relational phenomenon in everyday life. I furthermore depict my informants’ endless efforts of trying to attune to the rhythm of everyday life through different kinds of body work.

Besides focusing on what people do in their efforts to resynchronize their out-of-tune embodiment, another contribution of the article to the phenomenology of depression is to flesh out lived experiences of depression by providing evocative descriptions that are qualitatively different from those of philosophical reasoning. The empirical material that forms the basis of the thesis, offers certain valuable insights about experiences

of depression, insofar as it is generated from ethnographic fieldwork. This gives certain advantages that I use in the article. More specifically, I use my own body as an instrument of resonance to try to mediate what depression feels like. In this way, the article adds to phenomenological work on depression by experimenting with a stylistic way of writing that hopefully creates an echo in the reader and gives a better sense of what depression feels like.

Taken together, the three articles have presented accounts of depression that in overall terms argue that depression cannot be reduced to an individual or intra-psyche brain disorder, insofar as depression is experienced as a very bodily and relational phenomenon in everyday life. By emphasizing idiosyncratic, embodied, intersubjective, and cultural aspects of experiences of depression, I have offered an alternative to the dominant biological and brain-based understandings of depression. In the thesis I have furthermore underlined that experiences of depression are informed by and entangled with factors external to the individual such as normative ideals of being a good person, having a job, of being accepted in general and of contemporary dominant ways of understanding suffering. These contextual factors all shape experiences of depression, as well as the actions initiated to deal with the condition.

In the thesis, I have furthermore argued that the diagnosis of depression is negotiated, interpreted and used in a variety of ways by people living under the description of depression in everyday life. Hence, the incorporation of a depression diagnosis into the personal lives of the afflicted, happens in many different ways, pointing to a flexibility, creativity and selectivity in how adults experience, interpret and use a depression diagnosis in everyday life in the context of present-day diagnostic cultures.

10.4. AVENUES FOR FUTURE RESEARCH

Jackson writes that the ethnographer is influenced by both her initial preoccupations and the other's self-understandings in the research process. Hence, "the outcome of any intersubjective encounter is never a synthesis of all the various points of view taken together", Jackson writes, "but an arbitrary closure that leaves both self and other with a provisional and open-ended view that demands further dialogue and engagement" (Jackson, 2009: p.242).

There is an element of arbitrariness to the ethnographic enterprise, as Jackson tellingly puts it. Acknowledging that all research is somehow partial, I have tried to be transparent about my research process through the thesis by for example describing how my personal involvement with depression has informed the research process. At the same time, the work I have done has led to further ideas and potential future dialogues which it would be interesting to delve into. In this last section, I point to some of the

unexploited analytical possibilities in my empirical material, which would be interesting to examine further in future research.

In the first article, “Struggling with a depression diagnosis: Negotiations with diagnostic categories” I examine how one of my informants relate differently to the diagnosis over time, or more precisely over a period of eight months. I assume that the importance of a diagnosis most likely change over the years for others as well, along with the general flow of life where life situations change as well as central concerns in life. The interview I did with Jürgen, for instance, showed that the passage of time made him question the depression diagnosis, and to consider whether he was rather grieving because of the divorce he went through. In a future study, it would be interesting to do a longitudinal study with several adults diagnosed with depression in order to examine the time aspect of diagnostic processes in further details. Such a study could provide important insight into the meanings and significance of a depression diagnosis over a longer period of time, and how changes in the relation to the diagnosis might occur.

In closing, I also want to consider what kind of research paths I could have followed, and what kind of articles I could have written, if I had dared to make the most out of my emotional involvement with depression and diagnostic processes in the thesis. As mentioned previously, I particularly think that if I had used my own personal involvement with depression more creatively, it might have made me able to mediate more evocatively the indescribable nature of depression. Following the thoughts of Ruth Behar (1996), I believe that using this kind of vulnerability in ethnographic writing has the potential to mediate a greater depth of understanding of life with depression and experiences of diagnostic processes. In future research, it would be interesting to experiment with vulnerability in writing, insofar as it has the potential to make the reader identify more intensively with the topic and the persons one is writing about.

The relation between depression, gender and power is a huge topic within the vast literature on depression, as depicted in chapter 4. However, this has not been a pivotal point in the thesis, insofar as I have been interested in exploring experiences of depression and diagnostic processes that most likely cut across differences such as gender, age and socioeconomic status. However, reviewing my empirical material in a gender perspective, a future research project on depression could deal with the connection between gender, depression and the performance society (Petersen, 2016).

A common feature among my female interviewees were that they were all highly educated women with a committed, dutiful and curious approach to life. All of them described how they were very dedicated to their jobs, and I interpreted them as ambitious women who made a virtue of doing their best in whatever they were doing, whether it was to be a good wife, mother, friend or worker. These high demands also somehow played a part in how some of my female informants dealt with the diagnosis of depression. More specifically, they seemed to transfer these characteristics to how

they also approached depression. For example, it was striking how they all initiated their own little thorough research on depression after receiving the diagnosis. In this way, they were everything but passively receiving a depression diagnosis. Quite the contrary, they were very actively engaged in doing all the right things to try to recover from depression. Their high demands to their level of performance in several aspects of life also seemed to play a part in both causing depression and in shaping experiences of it. Elements in their narratives furthermore indicated a relation between certain gendered normative demands and depression.

Sarah, for instance, believed that there was a connection between what she considered to be certain female ideas about perfection and over-achievement and her outburst of depression. She believed that she experienced more stress on a daily basis than her husband for instance, insofar as she was the one, not her husband, who remembered to prepare the children's daily lunchboxes, to buy new clothes for the children, and to take them to the hairdresser to make sure that "they looked proper". She emphasized how her husband did not care about these appearance matters to the same extent as she did. This made Sarah ponder whether women in particular tend to make too high demands on themselves and each other in certain situations. She for instance thought that it is a certain female thing to make healthy and organic lunchboxes, to bring homemade bread to parent meetings, to make sure the home looks presentable, and that one's own outer appearance is perfect as well. At least in Sarah's case, she experienced these normative demands as gendered and particular female, and she believed they played a part in causing her depression. Hence, she tried to learn to lower her expectations to herself and to navigate after less perfect standards to hopefully avoid becoming ill with depression again in the future.

In future research it would be interesting to explore whether adults suffering from depression do experience certain female and masculine ideals to cause depression and shape experiences of it. Such a project could also involve a focus on the performance society, as Anders Petersen has termed the societal conditions we currently live by in contemporary Denmark (Petersen, 2016). Petersen does not have a gendered perspective in his work either, but he argues that certain normative demands, such as the request for an active and resilient self, have put a significant pressure on the contemporary human being that makes us vulnerable to depression. He argues that the chronic strains of the performance society are central to the proliferation of depression, insofar as many people find it difficult to measure up to these. It would be interesting to examine the gendered aspects of the performance society and its relations to depression in future research.

In this context, a national cohort study from Denmark, I have mentioned previously, becomes relevant (Skovlund et al., 2017). The study analyzes trends in depression diagnoses and the use of antidepressants in relation to age and gender. The study documents an increasing rate of depression with an earlier onset. It finds that incident of depression diagnoses for both men and women, aged between 10-49 years, increased

from 2000-2013. The study also finds an increase in first use of antidepressant in the same period. The findings show that before puberty, the incidence of depression and first use of antidepressants, is the same for boys and girls. However, interesting in relation to what I am pointing to here, the numbers for first use of antidepressant and incidence of depression diagnosed are higher for girls between 12-19 years than for boys during the same period. In this way, the study suggests that girls are more prone to depression than boys after puberty, and that an increasing number of young girls are prescribed antidepressants these years (Skovlund et al. 2017).

Together with the empirical tendencies regarding gender I have sketched above, these findings indicate that there is an alarming connection between gender (and maybe in particular young women), age and depression and the performance society, which it would be relevant to delve further into in future research.

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SUMMARY

In this thesis, I examine the complex experiences of what we call depression in everyday life, the multifaceted and ambiguous experiences of getting a depression diagnosis, and the in-depth processes involved in learning to live under the description of depression. The thesis is based on ethnographic fieldwork among adults diagnosed with depression in Denmark, and consists of three articles that provide glimpses into experiences of depression and diagnostic processes. The articles deal with creativity, variability and resistance in diagnostic processes and illustrates how these not are once-and-for-all-dealt-with matters but rather messy and complicated processes, that involve several actors and multiple relations to the diagnosis. The thesis furthermore challenges the dominant diagnostic understanding depression as a neurobiological, and individual disorder in present-day diagnostic cultures, by arguing that depression primarily is experienced as a bodily and relational phenomenon in quotidian life.